Medical Necessity / Level of Care Assessment (3.0 MN/LOC)
Item-by-Item Guide

September 2025

Table of Contents

Overview **1**
Purpose of the MNLOC Item-by-Item Guide 2
Assessment Purpose and When/How to Complete and Submit 3
Physician's Signature/Assessment Retention 4
Coding Conventions 4

SECTION A: IDENTIFICATION INFORMATION **5**
A0310: Type of Assessment 5
A0500: Legal Name of Individual 5
A0600: Social Security and Medicare Numbers 6
A0700: Medicaid Number 7
A0800: Gender 7
A0900: Birth Date 8
A1000: Race/Ethnicity 8
A1100: Language 9
A1300: Optional Individual Items 9
A1550: Conditions Related to Intellectual and Developmental Disability Status 10
A2300: Assessment Date 11

SECTION B: HEARING, SPEECH, AND VISION **12**
B0100: Comatose 12
B0200: Hearing 13
B0300: Hearing Aid 14
B0600: Speech Clarity 15
B0700: Makes Self Understood 16
B0799: Modes of Expression 17
B0800: Ability to Understand Others 18
B1000: Vision 19
B1200: Corrective Lenses 20

SECTION C: COGNITIVE PATTERNS **22**
C0100: Should Brief Interview for Mental Status Be Conducted? 22
C0200-C0500: Brief Interview for Mental Status (BIMS) 23
C0200: Repetition of Three Words 26
C0300: Temporal Orientation (Orientation to Year, Month, and Day) 28
C0400: Recall 31
C0500: BIMS Summary Score 33
C0600: Should the Caregiver Assessment for Mental Status (C0700- C1000) Be Conducted? 35
C0700: Short-term Memory OK 37
C0800: Long-term Memory OK 38
C0900: Memory/Recall Ability 39
C1000: Cognitive Skills for Daily Decision Making 40
C1310: Signs and Symptoms of Delirium (from CAM©) 43

SECTION D: MOOD 48
D0100: Should Individual Mood Interview Be Conducted? 48
D0200: Individual Mood Interview (PHQ-9©) 49
D0300: Total Severity Score 54
D0500: Caregiver Assessment of Individual Mood (PHQ-9-OV©) 56
D0600: Total Severity Score 59

SECTION E: BEHAVIOR 60
E0100: Potential Indicators of Psychosis 60
E0200: Behavioral Symptom—Presence & Frequency 62
E0300: Overall Presence of Behavioral Symptoms 64
E0500: Impact on Individual 64
E0600: Impact on Others 66
E0800: Rejection of Care—Presence & Frequency 68
E0900: Wandering—Presence & Frequency 70
E1000: Wandering—Impact 71
E1100: Change in Behavior or Other Symptoms 73

SECTION GG: FUNCTIONAL ABILITIES 74
GG0100. Prior Functioning: Everyday Activities 74
GG0110. Prior Device Use 77
GG0115: Functional Limitation in Range of Motion 78
GG0120: Mobility Devices 80
GG0130: Self-Care (3-day assessment period) Admission 82
GG0130: Self-Care (3-day assessment period) Discharge 83
GG0130: Self-Care (OBRA/Interim) 84
GG0170: Mobility (3-day assessment period) Admission 101

SECTION H: BLADDER AND BOWEL 130
H0100: Appliances 130
H0200: Urinary Toileting Program 132
H0300: Urinary Continence 134
H0400: Bowel Continence 136
H0500: Bowel Continence Program 137
H0600: Bowel Patterns 138

SECTION I: ACTIVE DIAGNOSES 140

SECTION J: HEALTH CONDITIONS 151
J0100: Pain Management 151
J0200: Should Pain Assessment Interview Be Conducted? 154
J0300: Pain Presence 157
J0400: Pain Frequency 158
J0500: Pain Effect on Function 159
J0600: Pain Intensity 161
J0700: Should the Caregiver Assessment for Pain be Conducted? 163

J0800: Indicators of Pain 164
J0850: Frequency of Indicator of Pain or Possible Pain 167
J1100: Shortness of Breath (dyspnea) 168
J1400: Prognosis 170
J1550: Problem Conditions 171
J1700: Fall History 172
J1900: Number of Falls in the last 6 months with or without Injury 175
J2000: Prior Surgery 177

SECTION K: SWALLOWING/NUTRITIONAL STATUS 179
K0100: Swallowing Disorder 179
K0200: Height and Weight 180
K0300: Weight Loss 181
K0310: Weight Gain 183
K0510: Nutritional Approaches 184
K0710: Percent Intake by Artificial Route 186

SECTION L: ORAL/DENTAL STATUS 189

SECTION M: SKIN CONDITIONS 191
M0100: Determination of Pressure Ulcer/Injury Risk 191
M0150: Risk of Pressure Ulcers/Injuries 193
M0210: Unhealed Pressure Ulcers/Injuries 193
M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage 195
M1030: Number of Venous and Arterial Ulcers 203
M1040: Other Ulcers, Wounds and Skin Problems 204
M1200: Skin and Ulcer/Injury Treatments 208

SECTION N: MEDICATIONS 212
N0300: Injections 212
N0350: Insulin 213
N0410: Medications Received 214

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS 219
O0100: Special Treatments, Procedures, and Programs 219
O0400: Therapies 223
O0420: Distinct Calendar Days of Therapy 229
O0500: Restorative Nursing Programs 230
O0600: Physician Examinations 233
O0700: Physician Orders 234

SECTION P: RESTRAINTS AND ALARMS 236
P0100: Physical Restraints 236
P0200: Alarms 240

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING 243
Q0100: Participation in Assessment 243
Q0300: Individual's Overall Expectation 244

SECTION Z: ASSESSMENT ADMINISTRATION 246

LTC Medicaid Information 247
S1. Medicaid Information 247
S2. Claims Processing Information 247
S3. Primary Diagnosis 248
S4. For DADS use only 248
S5. Licenses 249
S6. Additional MN Information 250
S7. Physician's Evaluation and Recommendation 253
S9. Medications (30-Day Look-back) 254
S10. Comments 260
S11. Advance Care Planning 261
S12. LAR Address 262

Appendix I – PDPM LTC Items ..... Error! Bookmark not defined.
Appendix II – Revisions Table 263

Overview

This guide is to be used in conjunction with the Medical Necessity and Level of Care Assessment (MN/LOC Assessment). A blank copy of the MN/LOC can be found at: https://www.tmhp.com/programs/ltc/forms. The MN/LOC Assessment includes the following sections:

- Section A: Identification Information
- Section B: Hearing, Speech, and Vision
- Section C: Cognitive Patterns
- Section D: Mood
- Section E: Behavior
- Section GG: Functional Abilities
- Section H: Bladder and Bowel
- Section I: Active Diagnosis
- Section J: Health Conditions
- Section K: Swallowing/Nutritional Status
- Section L: Oral/Dental Status
- Section M: Skin Conditions
- Section N: Medications
- Section O: Special Treatments, Procedures, and Procedures
- Section P: Restraints and Alarms
- Section Q: Participation in Assessment and Goal Setting
- Section Z: Assessment Administration
- LTC Medicaid Information: Texas Specific Item

Note: *Since this manual and MN/LOC forms were last updated in 2025, CMS has published several changes to both the Minimum Data Set Assessment forms and to the MDS 3.0 Resident Assessment Instrument User's Manual (RAI). This MN/LOC Item-by-Item Guide only reflects the changes that are necessary to update to the PDPM LTC Payment Level system requirements; therefore, not every component of the current MDS 3.0 assessment is represented in this version of the MN/LOC.*

Please read each set of instructions carefully when completing the assessment and only respond to the questions listed in the current form. A link to the RAI User's manual can be found at: https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf

1. *The latest version of the MNLOC can be found on the bottom of the page titled "Medical Necessity and Level of Care 3.0 Assessment" under the heading "Communty Waiver Programs."*

Purpose of the MN/LOC Item-by-Item Guide

This guide provides information to facilitate an accurate and uniform assessment focused on:

- **Intent**. The reason(s) for including this set of assessment items in the MN/LOC.
- **Item Display**. Each assessment section is accompanied by screen-shots, which display the item from the MN/LOC 3.0 item set.
- **Item Rationale**. The purpose of assessing this aspect of an individual's clinical or functional status.
- **Health-related Quality of Life**. How the condition, impairment, improvement, or decline being assessed can affect an individual's quality of life, along with the importance of caregiver understanding the relationship of the clinical or functional issue related to quality of life.
- **Planning for Care**. How assessment of the condition, impairment, improvement, or decline being assessed can contribute to appropriate care planning.
- **Steps for Assessment**. Sources of information and methods for determining the correct response for coding each MN/LOC item.
- **Coding Instructions**. The proper method of recording each response, with explanations of individual response categories.
- **Coding Tips and Special Populations**. Clarifications, issues of note, and conditions to be considered when coding individual MN/LOC items.
- **Examples**. Case examples of appropriate coding for most MN/LOC sections/items.

Additional layout issues to note include:

- Important definitions are included in each section.
- Pediatric Tips are included in each section as appropriate.
- All look-back periods are 7 days unless otherwise noted below the item.

Note: Certain Section GG items have a 3 day look-period; the ARD and the two days prior. Review each section carefully and refer to the CMS MDS 3.0 RAI Users manual for further guidance. Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.19.1.

MN/LOC Assessment Purpose

The MN/LOC is used by the following Community Programs: Community First Choice (CFC) Program, Medically Dependent Children Program (MDCP), Program of All-Inclusive Care for the Elderly (PACE), and the STAR+PLUS Home and Community-based Services (STAR + PLUSHCBS) to:

Supply current information that is used by medical professionals at Texas Medicaid & Healthcare Partnership (TMHP) to determine medical necessity (MN) for individuals. MN is the determination that an individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care. A determination that an individual meets MN is required for an individual to participate in CFC, MDCP, PACE, and SPW HCBS.

Determine the Patient Driven Payment Model Long-term Care (PDPM LTC) level. The PDPM LTC is a systematic approach to categorize the care needs of an individual. The Texas Medicaid & Healthcare Partnership (TMHP) automated system uses a mathematical algorithm to calculate a PDPM LTC level. This algorithm is used in all cases to automatically generate a PDPM LTC level based on the information entered on the MN/LOC Assessment by the assessing nurse. The PDPM LTC level is used to establish the service plan cost limit in MDCP and STAR+PLUS HCBS.

PDPM LTC Training

PDPM LTC training must be completed every two years to complete and submit assessments. After training is completed, the nurse's license number is registered with the Texas Medicaid Healthcare Partnership (TMHP). The PDPM LTC training will be effective for a two-year period. HHSC will accept current RUG certifications until they expire (2 years after the completion date).

When to Complete and Submit an Assessment

Use the MN/LOC Assessment to submit assessment information necessary for TMHP to determine:

1) Medical necessity; and **2)** PDPM LTC level

How to Complete and Submit an Assessment

MN/LOC Assessments can only be submitted on the TMHP LTC Online Portal. TMHP's LTC Online Portal can be accessed via www.tmhp.com. TMHP conducts community service waiver program workshops that detail how to create an account for access to the TMHP LTC Online Portal. Details can be found at www.tmhp.com.

TMHP receives a monthly feed of valid registered nurse (RN) license numbers from the Texas Board of Nursing. Depending on dates, a nurse can renew the license timely, but if done close to the end of the expiration month, it could result in TMHP not receiving information of the renewal until the following month. To avoid this possibility, and ensure MN/LOC Assessments can be submitted on the TMHP LTC Online Portal, it is recommended that nurses renew their license a month prior to the expiration date.

Physician's Signature

A Physician's Signature page can be generated and printed from the TMHP LTC Online Portal for Initial, Annual, and Significant Change in Status Assessments. A physician's signature is required when submitting an Initial Assessment (when 01 is selected as the Reason for Assessment in Field A0310).

Initial Assessments ***cannot be submitted unless*** *the physician has signed the statement on the Physician Signature Page* certifying the applicant requires Nursing Facility services or alternative community-based services under the supervision of an MD/DO. A physician's signature is optional for Annual and Significant Change in Status Assessments.

Assessment Retention

Keep the electronic and/or handwritten assessment with appropriate original signatures in the individual's record in accordance with all applicable Texas Health and Human Services Commission (HHSC) record retention rules and your agency's policies.

> **Note**: In 2017, the Department of Aging and Disability Services (DADS) was absorbed into Texas HHSC. However, the MN/LOC form may still refer to "DADS" in several locations.

Coding Conventions

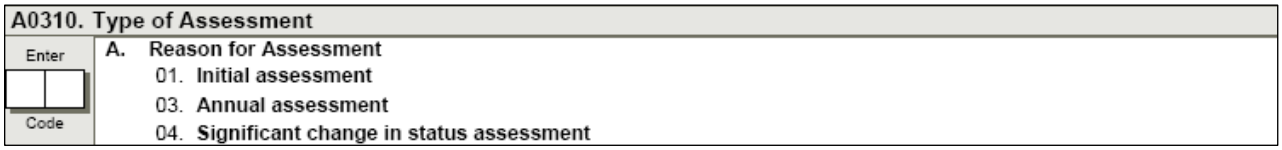
There are several standard conventions to be used when completing the MN/LOC Assessment, as follows.

- The standard look-back period for the MN/LOC 3.0 is 7 days, unless otherwise stated as in the following sections: D, GG, J, K, O, and Long-Term Care Medicaid Information (LTCMI).
- The Assessment Date (A2300) establishes the endpoint for all look-back periods.
- Responses entered on the LTMCI must not conflict with the responses entered on other sections of the MN/LOC Assessment.
- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another. This is called a skip pattern. When you encounter a skip pattern, leave the item blank and move on to the next item as directed (For example, item B0100, **Comatose**, directs the assessor to skip to item GG0100 **Activities of Daily Living Assistance**, if B0100 is answered **code 1, yes.** The intervening items from B0200- F0800 would not be coded. If B0100 were recorded as **code 0, no,** then the assessor would continue with item B0200).
- Use a check mark for boxes where the instructions state to "check all that apply," if specified condition is met; otherwise these boxes remain blank.
- Use a numeric response (a number or pre-assigned value) for blank boxes (For example,, D0350, Safety Notification).
- When recording month, day, and year for dates, enter two digits for the month and the day, and four digits for the year.
- Some MN/LOC 3.0 items allow a dash (-) value to be entered. A dash value indicates that an item was not assessed.
- **NONE OF ABOVE** is a response item to several items. Check this item where none of the responses apply; it should not be used to signify lack of information about the item.

SECTION A: IDENTIFICATION INFORMATION

Intent: The intent of this section is to obtain key information to uniquely identify the individual and the reason for assessment.

A0310: Type of Assessment



Item Rationale

- Allows identification of needed assessment content.

Coding Instructions for A0310, Type of Assessment

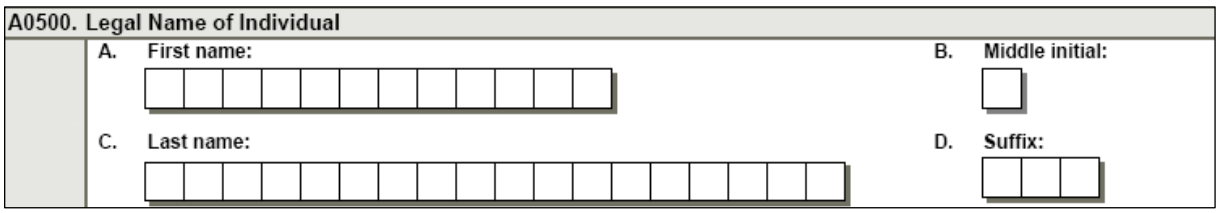
Enter the Reason for Assessment:

01 Initial Assessment - An Initial Assessment is completed when an individual is admitted to a Community Program. Please refer to the specific Community Program handbook or rules to determine if an MN/LOC must be completed for individuals transitioning from a Nursing Facility (NF) to a specific Community Program. In some instances, the MN and PDPM LTC value determined by the Nursing Facility (NF) assessment (the Minimum Data Set [MDS]) may be valid for the Community Program.

03 Annual Assessment - An Annual Assessment is required yearly. It must be submitted up to 90 days prior to the end of the service plan. Rejection of an Annual Assessment will occur if it is submitted more than 90 days prior to the service plan end date.

04 Significant Change in Status Assessment (SCSA) – For the purposes of this assessment process, a significant change is a decline in an individual's condition that could potentially increase their current PDPM LTC value. A SCSA does not apply for PACE. For MDCP and SPW refer to the program handbook to determine if a SCSA must be authorized prior to submission on the TMHP LTC Online Portal.

A0500: Legal Name of Individual



Definitions

- **Legal Name** - The individual's name as it appears on the Medicaid card. If the individual is not enrolled in the Medicaid program, use the name as it appears on a government issued document (That is, driver's license, birth certificate, social security card).

Item Rationale

- Allows identification of the individual
- Also used for matching of records

Steps for Assessment

1. Ask the individual, caregiver, or legally authorized representative (LAR).
2. Check the individual's name on his or her Medicaid card, or if not in the program, check other government-issued document.

Coding Instructions

Use printed letters. Enter in the following order:

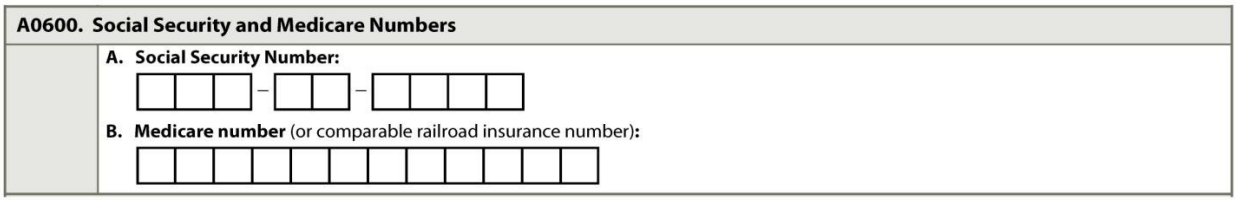
A. First Name

B. Middle Initial (if the individual has no middle initial, leave Item A0500B blank; if the individual has two or more middle names, use the initial of the first middle name)

C. Last Name

D. Suffix (For example, Jr./Sr.)

A0600: Social Security and Medicare Numbers



Definitions

- **Social Security Number-** A tracking number assigned to an individual by the U.S. federal government for taxation, benefits, and identification purposes.
- **Medicare Number** (or comparable Railroad Insurance Number) - An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier may be different from an individual's social security number (SSN), and may contain both letters and numbers. For example, many individuals may receive Medicare benefits based on a spouse's Medicare eligibility.

Item Rationale

- Allows identification of the individual.
- Allows for matching of records.

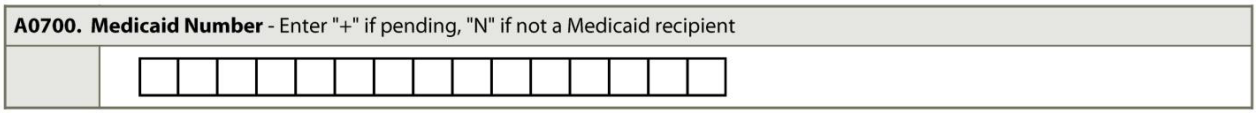
Coding Instructions

- A0600A or A0600B is required but not both.
- Enter the social security number in A0600A, one number per space starting with the leftmost space. If no social security number is available for the individual (For example, if the individual is a recent immigrant or a child) enter the Medicaid number (if Medicaid number is used make note of this in the LTCMI S10, Comments).
- Enter Medicare number in A0600B exactly as it appears on the individual's documents.
- If the individual does not have a Medicare number, another type of basic insurance identification code (For example, railroad retirement insurance code) may be substituted. These codes may contain both letters and numbers. To enter the railroad retirement code, enter the first letter of the code in the leftmost space followed by one digit per space.

Coding Tips and Special Populations

- The health maintenance organization (HMO) number is not the Medicare number. It is not entered into A0600B.
- Confirm that the individual's name on the MN/LOC matches the individual's name on the Medicare card and/or social security card.

A0700: Medicaid Number



Item Rationale

- Assists in correct identification.

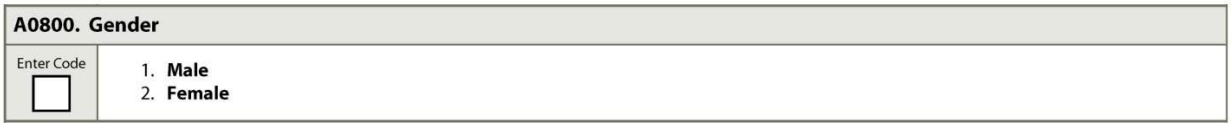
Coding Instructions

- Record this number if the individual is a Medicaid recipient.
- Enter one number per box beginning in the leftmost box.
- Recheck the number to make sure you have entered the digits correctly.
- Enter a "+" in the leftmost box if the number is pending. If you are notified later that the individual does have a Medicaid number, just include it on the next assessment.
- If not applicable because the individual is not a Medicaid recipient, enter "N" in the leftmost box.

Coding Tips and Special Populations

- To obtain the Medicaid number, check the individual's Medicaid card.
- Confirm that the individual's name on the MN/LOC matches the individual's name on the Medicaid card.

A0800: Gender



Item Rationale

- Assists in correct identification.
- Provides demographic gender specific health trend information.

Coding Instructions

- **Code 1:** if individual is male.
- **Code 2:** if individual is female.

Coding Tips and Special Populations

- The individual's gender on the MN/LOC should match what is in the social security system.
-

A0900: Birth Date

A0900. Birth Date	
	Month – Day – Year

Item Rationale

- Assists in correct identification.
- Allows determination of age.

Coding Instructions

- Fill in the boxes with the appropriate birth date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0." For example: January 2, 1948, should be entered as 01-02-1948.
-

A1000: Race/Ethnicity

A1000. Race/Ethnicity	
↓ Check all that apply	
☐	A. American Indian or Alaska Native
☐	B. Asian
☐	C. Black or African American
☐	D. Hispanic or Latino
☐	E. Native Hawaiian or Other Pacific Islander
☐	F. White

Item Rationale

- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial and ethnic categories. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Provides demographic race/ethnicity specific health trend information.

Steps for Assessment: Interview Instructions

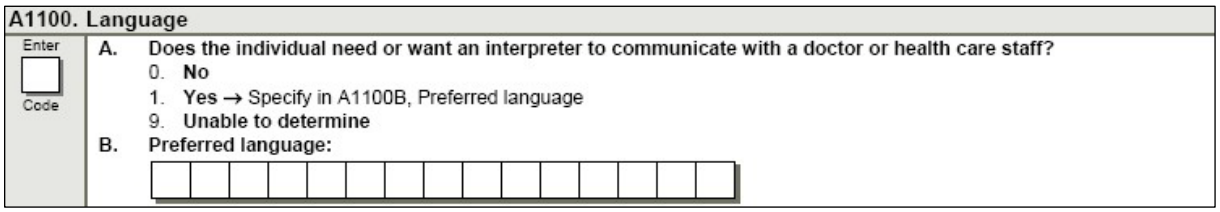
1. Ask the individual to select the category or categories that most closely correspond to his or her race/ethnicity from the list in A1000.
2. Individuals may be more comfortable if this is introduced by saying, "We want to make sure that all individuals get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can make sure that everyone gets the highest quality of care" (Baker et al., 2005).
3. If the individual is unable to respond, ask the caregiver or LAR.
4. Respondents should be offered the option of selecting one or more racial designations.
5. Only if the individual is unable to respond and caregiver or LAR is unavailable, observer identification or medical record documentation may be used.

Coding Instructions

Check all that apply.

- Enter the race or ethnic category or categories the individual, caregiver, or LAR uses to identify him or her.

A1100: Language



Item Rationale

Health-related Quality of Life

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can result in isolation, depression, and unmet needs.
- Language barriers can interfere with accurate assessment.

Planning for Care

- An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the individual to point to (if able).
- Identifies individuals who need interpreter services to answer interview items or participate in consent process.

Steps for Assessment

1. Ask the individual if he or she needs or wants an interpreter to communicate.
2. If the individual is unable to respond, a caregiver should be asked.
3. If an interpreter is wanted or needed, ask for preferred language.

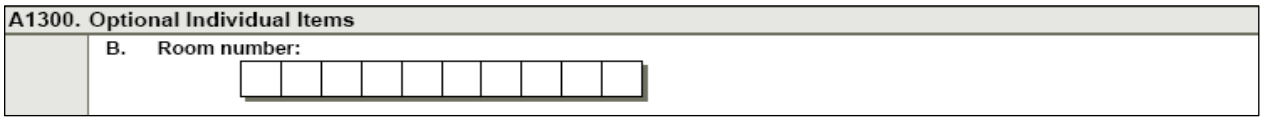
Coding Instructions

- **Code 0, no:** if the individual or caregiver does not want or need an interpreter to communicate.
- **Code 1, yes:** if the individual or caregiver needs or wants an interpreter to communicate. Specify preferred language. Proceed to A1100B and enter the preferred language.
- **Code 9, unable to determine:** if no source can identify whether the individual or caregiver wants or needs an interpreter.

Coding Tips and Special Populations

- An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the individual needs or wants to communicate in this manner.

A1300: Optional Individual Items



Item Rationale

- This is an optional item.

Coding Instructions for A1300B, Room Number

- Enter the individual's room number if the individual resides in a community setting that assigns room numbers (such as an Assisted Living Facility).

A1550: Conditions Related to Intellectual and Developmental Disability Status

A1550. Conditions Related to IDD Status If the individual is 22 years of age or older, complete only if A0310A = 01 If the individual is 21 years of age or younger, complete always	
↓ Check all conditions that are related to IDD status that were manifested before age 22, and are likely to continue indefinitely	
	IDD With Organic Condition
☐	A. Down syndrome
☐	B. Autism
☐	C. Epilepsy
☐	D. Other organic condition related to IDD
	IDD Without Organic Condition
☐	E. IDD with no organic condition
	No IDD
☐	Z. None of the above

Definitions

- **IDD – IDD** is the acronym for Intellectual and Developmental Disability, formerly known as mental retardation (MR).
- **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.
- **Other Organic Condition related to IDD** - 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.

Item Rationale

- To document conditions associated with IDD.

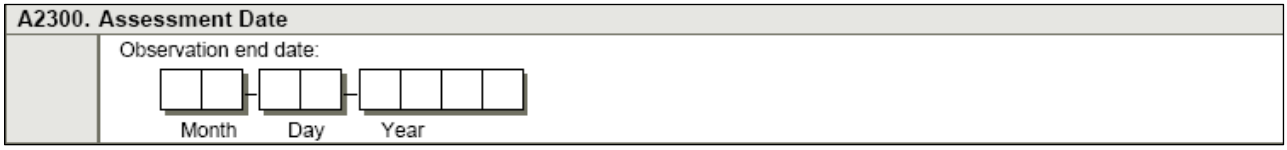
Steps for Assessment

1. If individual is 22 years of age or older on the assessment date, complete only if A0310A = 01 (Initial Assessment).
2. If individual is 21 years of age or younger on the assessment date, always complete.

Coding Instructions

- Check all conditions related to IDD status that was present before age 22.
- When the ages of onsets are 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 IDD is present.
    - **Code E:** if an IDD condition is present but the individual does not have any of the specific conditions listed.
    - **Code Z:** if no IDD is present.

A2300: Assessment Date



Item Rationale

- This date will establish an endpoint for the look-back period.

Steps for Assessment

1. Enter the date of the nurse assessor's face-to-face contact with the individual.

Coding Instructions

- Fill in the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0." For example: January 2, 2015, should be entered as 01-02-2015.

SECTION B: HEARING, SPEECH, AND VISION

Intent: The intent of items in this section is to document the individual's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the individual experiences visual limitations or difficulties related to diseases common in aged persons.

B0100: Comatose

B0100. Comatose	
Enter Code ☐	**Persistent vegetative state/no discernible consciousness** 0. **No** → Continue to B0200, Hearing 1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

Definitions

- **Comatose (Coma)** – A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (For example, pain)
- **Persistent Vegetative State** – Sometimes individuals, who were comatose after an anoxic-ischemic injury (That is, not enough oxygen to the brain) from a cardiac arrest head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.

Item Rationale

Health-related Quality of Life

- Individuals who are in a coma or persistent vegetative state are at risk for the complications of immobility, including skin breakdown and joint contractures.

Planning for Care

- Care planning should center on eliminating or minimizing complications and providing care consistent with the individual's health care goals.

Steps for Assessment

1. Review the medical record, if available, to determine if a neurological diagnosis of comatose or persistent vegetative state has been documented.

Coding Instructions

- **Code 0, no:** if a diagnosis of coma or persistent vegetative state is not present during the 7- day look-back period. Continue to B0200 **Hearing**.
- **Code 1, yes:** if the record indicates that a physician, nurse practitioner, physician assistant or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Skip to Section G0110, **Functional Status**.

Coding Tips

- Only code if a diagnosis of coma or persistent vegetative state has been assigned. For example, some individuals in advanced stages of progressive neuralgic disorders such as Alzheimer's disease may have severe cognitive impairment, be non-communicative and sleep a great deal of time; however, they are usually not comatose or in a persistent vegetative state, as defined here.
- Tocode **yes** to this item, there must be documentation of a corresponding diagnosis by a physician, nurse practitioner, physician assistant, or clinical nurse specialist.

B0200: Hearing

B0200. Hearing	
Enter Code ☐	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. **Moderate difficulty** - speaker has to increase volume and speak distinctly 3. **Highly impaired** - absence of useful hearing

Item Rationale

Health-related Quality of Life

- Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.
- Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.

Planning for Care

- Address reversible causes of hearing difficulty (such as cerumen impaction).
- Evaluate potential benefit from hearing assistance devices.
- Offer assistance to individuals with hearing difficulties to avoid social isolation.
- Consider other communication strategies for persons with hearing loss that is not reversible or is not completely corrected with hearing devices.
- Adjust environment by reducing background noise by lowering the sound volume on televisions or radios. A noisy environment can inhibit opportunities for effective communication.

Steps for Assessment

1. Ensure that the individual is using his or her normal hearing appliance (if they have one).
2. Interview the individual and ask about hearing function in different situations (hearing caregivers, talking to visitors, using telephone, watching TV, attending activities).
3. Observe the individual during your verbal interactions and when he or she interacts with others throughout the day.
4. Think through how you can best communicate with the individual For example, you may need to speak more clearly, use a louder tone, speak more slowly or use gestures. The individual may need to see your face to understand what you are saying, or you may need to take the individual to a quieter area for them to hear you. All of these are cues that there is a hearing problem.
5. Review the medical record, if available.
6. Consult the caregiver and speech or hearing specialists.

Coding Instructions

- **Code 0, adequate:** No difficulty in normal conversation, social interaction or listening to TV. The individual hears all normal conversational speech and telephone conversation.
- **Code 1, minimal difficulty:** Difficulty in some environments (For example when a person speaks softly or the setting is noisy). The individual hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations. The individual's hearing is adequate after environmental adjustments are made, such as reducing background noise by moving to a quiet room or by lowering the volume on television or radio.
- **Code 2, moderate difficulty:** Speaker has to increase volume and speak distinctly. Although

hearing-deficient, the individual compensates when the speaker adjusts tonal quality and speaks distinctly; or the individual can hear only when the speaker's face is clearly visible.

- **Code 3, highly impaired:** Absence of useful hearing. The individual hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Coding Tips for Special Populations

- Individuals who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods. The individual can be observed in their normal environment. Does he or she respond (For example, turn his or her head) when a noise is made at a normal level? Does the individual seem to respond only to specific noise in a quiet environment? Assess whether the individual responds only to loud noise or not at all.

Pediatric Tips:

- Ask parent/caregiver if a hearing test has been performed, if so and it is available, use this. Ask the parent/caregiver, if child responds to voice.
- Hearing can be measured grossly by calling name, looking for startle response to a loud noise (That is, dropping a book or clapping).

B0300: Hearing Aid

B0300. Hearing Aid	
Enter Code ☐	**Hearing aid or other hearing appliance used** in completing B0200, Hearing 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Problems with hearing can contribute to social isolation and mood and behavior disorders.
- Many individuals without hearing aids or other hearing appliances could benefit from them.
- Many persons who benefit from and own hearing aids do not use them, or the hearing aid is not functional.

Planning for Care

- Knowing if a hearing aid was used when determining hearing ability allows better identification of evaluation and management needs.
- For individuals with hearing aids, use and maintenance should be included in developing the plan of care.
- Individuals who do not have adequate hearing without a hearing aid should be asked about history of hearing aid use.
- Individuals who do not have adequate hearing despite wearing a hearing aid might benefit from a re-evaluation of the device or assessment for new causes of hearing impairment.

Steps for Assessment

1. Prior to beginning the hearing assessment, ask the individual if he or she owns a hearing aid or

other hearing appliance.

2. If the individual cannot respond, write the question down and allow them to read it.
3. If the individual is still unable, check with the caregiver about hearing aid or other hearing appliances.
4. Check the medical record for evidence that the individual had a hearing appliance in place when hearing ability was recorded.

Coding Instructions

- **Code 0, no:** if the individual did not use a hearing aid (or other hearing appliance) for the 7 day hearing assessment coded in **B0200, Hearing.**
- **Code 1, yes:** if the individual did use a hearing aid (or other hearing appliance) for the hearing assessment coded in **B0200, Hearing.**

B0600: Speech Clarity



B0600. Speech Clarity	
Enter Code ☐	Select best description of speech pattern 0. **Clear speech** - distinct intelligible words 1. **Unclear speech** - slurred or mumbled words 2. **No speech** - absence of spoken words

Definitions

- **Speech** – The verbal expression of articulate words

Item Rationale

Health-related Quality of Life

- Unclear speech or absent speech can hinder communication and be very frustrating to an individual.
- Unclear speech or absent speech can result in physical and psychosocial needs not being met and can contribute to depression and social isolation.

Planning for Care

- If speech is absent or is not clear enough for the individual to make needs known, other methods of communication should be explored.
- Lack of speech clarity or ability to speak should not be mistaken for cognitive impairment.

Steps for Assessment

1. Listen to the individual.
2. Ask primary caregivers about the individual's speech pattern.
3. Review the medical record.
4. Determine the quality of the individual's speech, not the content or appropriateness—just words spoken.

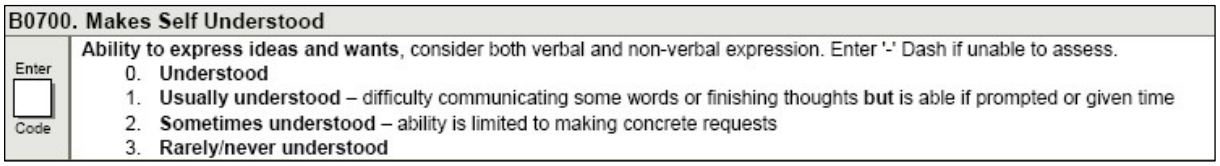
Coding Instructions

- **Code 0, clear speech:** if the individual usually utters distinct, intelligible words.
- **Code 1, unclear speech:** if the individual usually utters slurred or mumbled words.
- **Code 2, no speech:** if there is an absence of spoken words.

Pediatric Tip:

- **Code 2**, no speech-absence of spoken words, for infants and for all children who do not speak.

B0700: Makes Self Understood



B0700. Makes Self Understood	
Enter Code	**Ability to express ideas and wants**, consider both verbal and non-verbal expression. Enter '-' Dash if unable to assess. 0. **Understood** 1. **Usually understood** – difficulty communicating some words or finishing thoughts **but** is able if prompted or given time 2. **Sometimes understood** – ability is limited to making concrete requests 3. **Rarely/never understood**

Definitions

- **Makes Self Understood –** Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make oneself understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.

Item Rationale

Health-related Quality of Life

- Problems making self-understood can be very frustrating for the individual and can contribute to social isolation and mood and behavior disorders.
- Unaddressed communication problems can be inappropriately mistaken for confusion or cognitive impairment.

Planning for Care

- Ability to make self-understood can be optimized by not rushing the individual, breaking longer questions into parts, waiting for reply, and maintaining eye contact (if appropriate).
- If an individual has difficulty making self-understood:
  - Identify the underlying cause or causes.
  - Identify the best methods to facilitate communication for that individual.

Steps for Assessment

1. Assess using the individual's preferred language.
2. Interact with the individual. Be sure he or she can hear you or have access to his or her preferred method for communication. If the individual seems unable to communicate, offer alternatives such as writing, pointing or using cue cards.
3. Observe his or her interactions with others in different settings and circumstances.
4. Consult with the primary caregiver and the individual's speech-language pathologist (if applicable).

Coding Instructions

- **Code 0, understood:** if the individual expresses requests and ideas clearly.
- **Code 1, usually understood:** if the individual has difficulty communicating some words or finishing thoughts but is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self-understood.
- **Code 2, sometimes understood:** if the individual has limited ability but is able to express

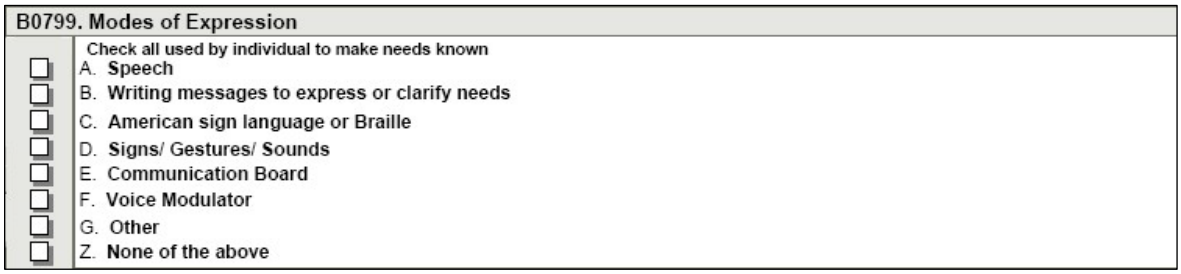
concrete requests regarding at least basic needs (For example, food, drink, sleep, and toilet).

- **Code 3, rarely or never understood:** if, at best, the individual's understanding is limited to interpretation by caregivers of highly individualized, specific sounds or body language (For example, indicated presence of pain or need to toilet).

Pediatric Tip:

- Assess the child to determine his ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these. Interact with the child. Observe and listen to the child's efforts to communicate with you. Observe their interactions with others in different settings (For example, one- on-one, groups) and different circumstances (For example, when calm, when agitated). Consult with the caregiver is anticipating all of the child's needs. Choose the code that best describes the child's ability to be understood.
- Look at the ability of the child to express self in different situations. Focus on whether or not the caregiver is able to understand the child usually, sometimes, or rarely.
- Example: If a toddler is able to point to an empty sippy cup to denote wants something to drink, but is unable to tell the caregiver all their wants, code that as 2, sometimes understood.

B0799: Modes of Expression



Record the types of verbal and non-verbal communication techniques used by the individual to make their needs and wishes known.

Coding Instructions

Check all those that apply during the 7-day look-back.

A. Speech

B. Writing messages to express or clarify needs- Individual writes notes to communicate with others.

C. American Sign Language or Braille

D. Signs/Gestures/Sounds- This includes verbal and non-verbal expressions used by the individual to communicate with others. Actions may include pointing to words, people; facial expressions; using physical gestures such as nodding head twice for "yes" and once for 'no' or squeezing another's hand in the same manner. Sounds may include grunting, banging, ringing a bell, etc.

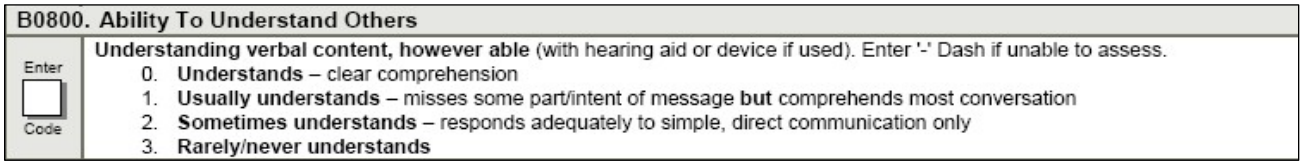
E. Communication Board- An electronic, computerized or other homemade device used by the individual to convey verbal information, wishes, or commands to others.

F. Voice Modulator- An assistive listening device

G. Other- Examples include flash cards or various electronic assistive devices.

Z. None of the above- If individual does not use any of the options for communication.

B0800: Ability to Understand Others



Definitions

- **Ability to Understand Others –** Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the individual's ability to process and understand language. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written) or recognition of facial expressions.

Item Rationale

Health-related Quality of Life

- Inability to understand direct person-to-person communication
    - Can severely limit association with others.
    - Can inhibit the individual's ability to follow instructions that can affect health and safety.

Planning for Care

- Thorough assessment to determine underlying cause or causes is critical todevelop a plan of care to address the individual's specific deficits and needs.
- Every effort should be made by caregivers to provide information to the individual in a consistent manner that he or she understands based on an individualized assessment.

Steps for Assessment

1. Assess using the individual's preferred language.
2. If the individual uses a hearing aid, hearing device or other communications enhancement device, he or she should use that device during the evaluation of their understanding of person-to-person communication.
3. Interact with the individual and observe his or her understanding of other's communication.
4. Consult with caregivers and the speech-language pathologist (if applicable).
5. Review the medical record for indications of how well the individual understands others.

Coding Instructions

- **Code 0, understands:** if the individual clearly comprehends the message(s) and demonstrates comprehension by words or actions/behaviors.
- **Code 1, usually understands:** if the individual misses some part or intent of the message **but** comprehends most of it. The individual may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- **Code 2, sometimes understands:** if the individual demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or instructions. When rephrased or simplified the message(s) comprehension is enhanced.
- **Code 3, rarely/never understands:** if the individual demonstrates very limited ability to

understand communication; if there is difficulty determining whether or not the individual comprehends messages based on verbal and nonverbal responses; if the individual can hear sounds but does not understand messages.

- **Code "-"Dash,** if unable to assess.

Pediatric Tip:

- Assess the child's ability to understand verbal content.
- For a severely autistic child you would most likely code "-" dash indicating the item was not assessed.
- Code "-" dash for an infant or toddler who cannot be assessed for this item due to age.

B1000: Vision

B1000. Vision	
Enter Code ☐	**Ability to see in adequate light** (with glasses or other visual appliances) 0. **Adequate** - sees fine detail, such as regular print in newspapers/books 1. **Impaired** - sees large print, but not regular print in newspapers/books 2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired** - object identification in question, but eyes appear to follow objects 4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

Definitions

- **Adequate Light** - Lighting that is sufficient or comfortable for a person with normal vision to see fine detail.

Item Rationale

Health-related Quality of Life

- A person's reading vision often diminishes over time.
- If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books, or correspondence, and maintaining and enjoying hobbies and other activities. It also limits the ability to manage personal business, such as reading and signing consent forms.
- Moderate, high or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood.

Planning for Care

- Reversible causes of vision impairment should be sought.
- Consider whether simple environmental changes such as better lighting or magnifiers would improve ability to see.
- Consider large print reading materials for persons with impaired vision.
- For individuals with moderate, high, or severe impairment, consider alternative ways of providing access to content of desired reading materials or hobbies.

Steps for Assessment

1. Ask the caregiver about the individual's usual vision patterns during the 7-day look-back period (For example, is the individual able to see newsprint, menus, and greeting cards)?
2. Ask the individual about his or her visual abilities.
3. Test the accuracy of your findings:
    - Ensure that the individual's customary visual appliance for close vision is in place (For example, eyeglasses, magnifying glass).

- Ensure adequate lighting.
- Ask the individual to look at regular-size print in a book or newspaper. Then ask the individual to read aloud, starting with larger headlines and ending with the finest, smallest print. If the individual is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.

Coding Instructions

- **Code 0, adequate:** if the individual sees fine detail, such as regular print in newspapers/books.
- **Code 1, impaired:** if the individual sees large print, but not regular print in newspapers/books.
- **Code 2, moderately impaired:** if the individual has limited vision and is not able to see newspaper headlines but can identify objects in his or her environment.
- **Code 3, highly impaired:** if the individual's ability to identify objects in his or her environment is in question, but the individual's eye movements appear to be following objects (especially people walking by).
- **Code 4, severely impaired:** if the individual has no vision, sees only light, colors or shapes, or does not appear to follow objects with eyes.

Coding Tips and Special Populations

- Some individuals have never learned to read or are unable to read. In such cases, ask the individual to read numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).
- If the individual is unable to communicate or follow your directions for testing vision, observe the individual's eye movements to see if his or her eyes seem to follow movement of objects or people. These gross measures of visual acuity may assist you in assessing whether or not the individual has any visual ability. For individuals who appear to do this, **code 3, highly impaired.**

Pediatric Tips:

- Ask caregiver if a vision test was done, if available, use the results.
- Use tracking as a gross measurement of vision if unable to assess in other ways. Infants should be able to track at approximately age 4-6 months.
- **Code 0, Adequate**, for older infants and toddlers if they reach for a toy placed in their field of vision.

B1200: Corrective Lenses

B1200. Corrective Lenses	
Enter Code ☐	**Corrective lenses (contacts, glasses, or magnifying glass) used** in completing B1000, Vision 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Decreased ability to see can limit the enjoyment of everyday activities and can contribute to social isolation and mood and behavior disorders.
- Many individuals who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient.

Planning for Care

- Knowing if corrective lenses were used when determining ability to see allows better identification of evaluation and management needs.
- Individuals with eyeglasses or other visual appliances should be assisted in accessing them. Use and maintenance should be included in developing the plan of care.
- Individuals who do not have adequate vision without eyeglasses or other visual appliances should be asked about history of corrective lens use.
- Individuals who do not have adequate vision, despite using a visual appliance, might benefit from a re-evaluation of the appliance or assessment for new causes of vision impairment.

Steps for Assessment

1. Prior to beginning the assessment, ask the individual whether he or she uses eyeglasses or other vision aids. Visual aids do not include surgical lens implants.
2. If the individual cannot respond, check with caregivers about the individual's use of vision aids during the 7-day look-back period.
3. Observe whether the individual used eyeglasses or other vision aids during reading vision test (B1000).
4. Check the medical record, if available, for evidence that the individual used corrective lenses when ability to see was recorded.

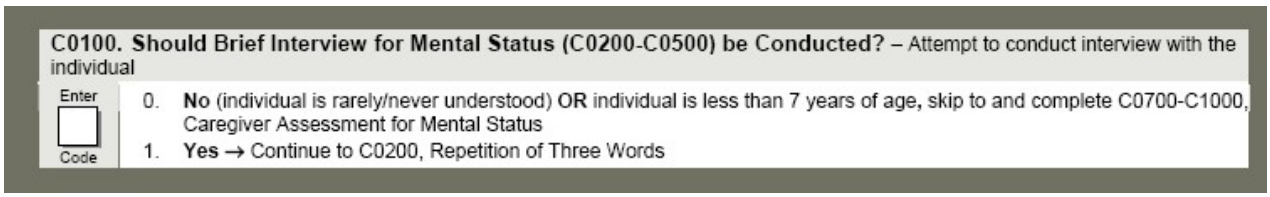
Coding Instructions

- **Code 0, no**: if the individual did not use eyeglasses or other vision aid during the B1000, Vision assessment.
- **Code 1, yes**: if corrective lenses or other visual aids were used when visual ability was assessed in completing B1000, Vision.

SECTION C: COGNITIVE PATTERNS

Intent: The items in this section are intended to determine the individual's attention, orientation, and ability to register and recall new information. Information entered S10 Comments regarding cognitive status and memory must be consistent with the information entered in this section.

C0100: Should Brief Interview for Mental Status Be Conducted?



Item Rationale

Health-related Quality of Life

- This information identifies if the interview will be attempted.
- Most individuals are able to attempt the Brief Interview for Mental Status (BIMS), a structured cognitive interview. A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
  - Without an attempted structured cognitive interview, an individual might be mislabeled based on his or her appearance or assumed diagnosis.
  - Structured interviews will efficiently provide insight into the individual's current condition that will enhance good care.

Planning for Care

- Structured cognitive interviews assist in identifying needed supports.
- The structured cognitive interview is helpful for identifying possible delirium behaviors (C1310).

Steps for Assessment

1. Review **Makes Self Understood** item (B0700), to determine if the individual is understood at least sometimes (B0700 = 0, 1, or 2). If rarely/never understood, skip to C0700-C1000, Caregiver Assessment for Mental Status.
2. Review **Language** item (A1100), to determine if the individual needs or wants an interpreter.
   - If the individual needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

Record whether the cognitive interview should be attempted with the individual.

- **Code 0, no:**
  - If the interview should not be attempted because the individual is rarely/never understood (B0700 = 3) verbally or in writing,
  - an interpreter is needed but not available, or
  - If the individual is less than 7 years old. Skip to **Caregiver Assessment of Mental Status.**
- **Code 1, yes:**
  - If the interview should be attempted because the individual is at least sometimes understood verbally or in writing (B0700 = 0, 1, or 2), and

- If an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

Coding Tip

Attempt to conduct the interview with ALL individuals. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.

- If the individual needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to be present on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, **Caregiver Assessment of Mental Status**, instead of C0200-C0500, **Brief Interview for Mental Status**.

Pediatric Tip

If the child is less than seven years old skip to C0600. If the child is seven years old or greater, use nursing judgment to determine whether to complete this section or skip to **Caregiver Assessment of Mental Status.**

C0200-C0500: Brief Interview for Mental Status (BIMS)

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask individual: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."* Enter '-' Dash if unable to assess.

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the individual's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask individual: *"Please tell me what year it is right now."* Enter '-' Dash if unable to assess.

A. Able to report correct year

0. **Missed by > 5 years or no answer**
1. **Missed by 2–5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code

Ask individual: *"What month are we in right now?"* Enter '-' Dash if unable to assess.

B. Able to report correct month

0. **Missed by >1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code

Ask individual: *"What day of the week is today?"* Enter '-' Dash if unable to assess.

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code

Ask individual: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. Enter '-' Dash if unable to assess.

A. Able to recall "sock"

0. **No** – could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code

B. Able to recall "blue"

0. **No** – could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code

C. Able to recall "bed"

0. **No** – could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score

The sum of the scores for questions C0200–C0400. The sum should be a number (00–15)
A score of 99 indicates that the individual was unable to complete one or more questions of the interview

Definitions

- **Nonsensical Response –** Any response that is unrelated, incomprehensible, or incoherent, it is not informative with respect to the item being rated.
- **Category Cue –** Phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the individual. The category cue for sock is "something to wear." The category cue for blue is "a color." For bed, the category cue is "a piece of furniture."
- **Temporal Orientation** – In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings.

Item Rationale

Health-related Quality of Life

- Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Cognitively intact individuals may appear to be cognitively impaired because of extreme frailty, hearing impairment, or lack of interaction.
- Some individuals may appear to be more cognitively intact than they actually are.
- If cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered.
- An individual's performance on cognitive tests can be compared over time.
    - If performance worsens, then an assessment for delirium and or depression should be considered.
- The BIMS is an opportunity to observe individuals for signs and symptoms of delirium (C1310).

Planning for Care

- Assessment of an individual's mental state provides a direct understanding of individual function that may:
    - Enhance future communication and assistance, and
    - Direct interventions to facilitate greater independence; include posting or providing reminders for self-care activities.
- An individual's performance on cognitive tests can be compared over time.
    - An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life-threatening illness.
    - A decline in mental status may also be associated with a mood disorder.
- Awareness of possible impairment may be important for maintaining a safe environment and providing safe discharge planning.

Steps for Assessment: Basic Interview Instructions for BIMS (C0200-C0500)

1. Interview any individual not screened out by **Should Brief Interview for Mental Status Be Conducted?** item (C0100).
2. Conduct the interview in a private setting.
3. Be sure the individual can hear you.
    - Individuals with hearing impairment should be tested using their usual communication

devices/techniques, as applicable.

- Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
- Minimize background noise.

4. Sit so that the individual can see your face. Minimize glare by directing light sources away from the individual's face.

Steps for Assessment: Basic Interview Instructions for BIMS (Continued)

5. Give an introduction before starting the interview. Suggested language:
   "I would like to ask you some questions. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult."

6. If the individual expresses concern that you are testing his or her memory, he or she may be more comfortable if you reply: "We ask these questions of everyone so we can make sure that care will meet your needs."
7. Directly ask the individual each item in C0200 through C0400 at one sitting and in the order provided.
8. If the individual chooses not to answer a particular item, accept his or her refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect.
9. On occasion, the interviewer may not be able to state the words clearly because of an accent or slurred speech. If the interviewer is unable to pronounce any of the three recall words in C0200 clearly, have a different interviewer complete this section.
10. When the individual's primary method of communication is in written format, the BIMS can be administered in writing. The administration of the BIMS in writing should be limited to this circumstance.

Coding Tips

- Nonsensical responses should be coded as zero
- Rules for stopping the interview before it is complete:
  --Stop the interview after completing (C0300C) "Day of the Week" if:
  1. All responses have been nonsensical (That is, any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated); OR
  2. There has been no verbal or written response to any of the questions up to this point; OR
  3. There has been no verbal or written response to some questions up to this point and for all others, the individual has given a nonsensical response.
- If the interview is stopped, do the following:
  1. Code a dash (-) in C0400A, C0400B, and C0400C.
  2. Code 99 in the summary score in C0500 (if the system does not already pre- populated with a 99).
  3. Code 1, yes in C0600 Should the Caregiver Assessment for Mental Status (C0700-C100) be conducted?
  4. Complete the Caregiver Assessment for Mental Status.

Examples of Incorrect and Nonsensical Responses

1. Interviewer asks Ms. C to state the year. She replies that it is 1935. This answer is incorrect but related to the question.

   Coding: This answer is **coded 0** but would NOT be considered a nonsensical response.
   Rationale: The answer is wrong, but it is logical and relates to the question.

2. Interviewer asks Mr. D to state the year. He says, "Oh what difference does the year make when you're as old as I am?" The interviewer asks him to try to name the year, and he shrugs.

   Coding: This answer is **coded 0** but would NOT be considered a nonsensical response.
   Rationale: The answer is wrong because refusal is considered a wrong answer, but the individual's comment is logical and clearly relates to the question.

3. Interviewer asks the Ms. L to name the day of the week. She answers, "Sylvia, she's my daughter."

   Coding: The answer is **coded 0**; the response is illogical and nonsensical.
   Rationale: The answer is wrong, and her comment clearly does not relate to the question; it is nonsensical.

C0200: Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask individual: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words." Enter '-' Dash if unable to assess.*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the individual's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

Item Rationale

Health-related Quality of Life

- Inability to repeat three words on first attempt may indicate:
  - A memory impairment;
  - A hearing impairment;
  - A language barrier; or
  - Inattention that may be a sign of delirium or another health issue.

Planning for Care

- A cue can assist learning.
- Cues may help individuals with memory impairment who can store new information in their memory but who have trouble retrieving something that was stored (For example, not able to remember someone's name but can recall if given part of the first name).
- Caregivers can use cues when assisting individuals with learning and recall in therapy, and in daily and restorative activities.

Steps for Assessment

1. Say to the individual: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed." Interviewers need to use the word and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.
2. Immediately after presenting the three words, say to the individual: "Now please tell me the three words."
3. After the individual's first attempt to repeat the items:
    - If the individual correctly stated all three words, say, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture" [category cues].
    - Category cues serve as a hint that helps prompt individuals' recall ability. Putting words in context stimulates learning and fosters memory of the words that individuals will be asked to recall in item C0400, even among individuals able to repeat the words immediately.
    - If the individual recalled two or fewer words, say to the individual: "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." If the individual still does not recall all three words correctly, you may repeat the words and category cues one more time.
    - If the individual does not repeat all three words after three attempts, re-assess ability to hear. If the individual can hear, move on to the next question. If he or she is unable to hear, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding.

Coding Instructions

Record the maximum number of words that the individual correctly repeated on the **first** *attempt. This will be any number between zeroand three.*

- The words may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.
- Do not score the number of repeated words on the second or third attempt. These attempts help with learning the item for C0400, Recall, but only the number correct on the first attempt goes into the total score. Do not record the number of attempts that the individual needed to complete.
- **Code 0, none:** if the individual did not repeat any of the three words on the first attempt.
- **Code 1, one:** if the individual repeated only one of the three words on the first attempt.
- **Code 2, two:** if the individual repeated only two of the three words on the first attempt.
- **Code 3, three:** if the individual repeated all three words on the first attempt.

Coding Tip

On occasion, the interviewer may not be able to state the words clearly because of an accent. If the interviewer is unable to pronounce any of the three words clearly, have a different interviewer conduct the interview.

Examples

1. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." Mr. G replies, "Bed, sock, and blue." The interviewer repeats the three words with category cues, by saying, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture."

Coding: C0200 would be **coded 3, three** words correct.
Rationale: He repeated all three items on the first attempt. The order of repetition does not affect the score.

2. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." Mrs. H replies, "Sock, bed, black." The interviewer repeats the three words plus the category cues, saying "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." She says "Oh yes, that's right, sock, blue, bed."

   Coding: C0200 would be **coded 2, two** of three words correct.
   Rationale: She repeated two of the three items on the first attempt. Individuals are scored based on the first attempt.

3. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." The individual says, "Blue socks belong in the dresser." The interviewer repeats the three words plus the category cues.

   Coding: C0200 would be **coded 2, two** of the three words correct.
   Rationale: Mr. L repeated two of the three items—blue and sock. He put the words into a sentence, resulting in repeating two of the three words.

4. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." Ms. K replies, "What were those three words?" The interviewer repeats the three words plus the category cues.

   Coding: C0200 would be **coded 0, none** of the words correct.
   Rationale: She did not repeat any of the three words after the first time the interviewer said them.

C0300: Temporal Orientation (Orientation to Year, Month, and Day)

C0300. Temporal Orientation (orientation to year, month, and day)

Ask individual: *"Please tell me what year it is right now." Enter '-' Dash if unable to assess.*

Enter Code

A. Able to report correct year
0. Missed by > 5 years or no answer
1. Missed by 2–5 years
2. Missed by 1 year
3. Correct

Ask individual: *"What month are we in right now?" Enter '-' Dash if unable to assess.*

Enter Code

B. Able to report correct month
0. Missed by >1 month or no answer
1. Missed by 6 days to 1 month
2. Accurate within 5 days

Ask individual: *"What day of the week is today?" Enter '-' Dash if unable to assess.*

Enter Code

C. Able to report correct day of the week
0. Incorrect or no answer
1. Correct

Item Rationale

Health-related Quality of Life

- A lack of temporal orientation may lead to decreased communication or participation in activities.
- Not being oriented may be frustrating or frightening.

Planning for Care

- If caregivers know that an individual has a problem with orientation, they can provide reorientation aids and verbal reminders that may reduce anxiety.
- Reorienting those who are disoriented or at risk of disorientation may be useful in treating symptoms of delirium.
- Individuals who are not oriented may need further assessment for delirium, especially if this fluctuates or is recent in onset.

Steps for Assessment

1. Ask the individual each of the three questions in Item C0300 separately.
2. Allow the individual up to 30 seconds for each answer and do not provide clues.
3. If the individual specifically asks for clues (For example, "is it bingo day?") respond by saying, "I need to know if you can answer this question without any help from me."

Coding Instructions for C0300A, Able to Report Correct Year

- **Code 0, missed by greater than5 years or no answer:** if the individual's answer is incorrect and is greater than 5 years from the current year or the individual chooses not to answer the item.
- **Code 1, missed by 2-5 years:** if the individual's answer is incorrect and is within two to five years from the current year.
- **Code 2, missed by 1 year:** if the individual's answer is incorrect and is within one year from the current year.
- **Code 3, correct:** if the individual states the correct year.

Examples

1. The date of interview is May 5, 2012. Mr. L, responding to the statement, "Please tell me what year it is right now," states that it is 2012.

   Coding: C0300A would be **coded 3, correct.**
   Rationale: 2012 is the current year.

2. The date of interview is June 16, 2012. Ms. Q, responding to the statement, "Please tell me what year it is right now," states that it is 2009.

   Coding: C0300A would be **coded 1, missed by 2-5 years.**
   Rationale: 2009 is within 2 to 5 years of 2012.

3. The date of interview is January 10, 2012. Mr. T, responding to the statement, "Please tell me what year it is right now," states that it is 1912.

   Coding: C0300A would be **coded 0, missed by more than 5 years.**
   Rationale: Even though the '12 part of the year would be correct, 1912 is more than five years from 2012.

4. The date of interview is April 1, 2012. Ms. M, responding to the statement, "Please tell me what year it is right now," states that it is "'12." The interviewer asks, "Can you tell me the full year?" She still responds "'12," and the interviewer asks again, "Can you tell me the full year, for example,

nineteen-eighty-two." She states, "2012."

Coding: C0300A would be **coded 3, correct.**
Rationale: Even though^12 is partially correct, the only correct answer is the exact year. She must state "2012," not "'12" or "1812" or "1912."

Coding Instructions for C0300B, Able to Report Correct Month

For C0200-C0400, also refer to Coding Instructions and Coding Tips for C0500 Summary Score
Count the current day as day one when determining whether the response was accurate within five days or missed by six days to one month.

- **Code 0, missed by greater than 1 month or no answer:** if the individual's answer is incorrect by more than one month or if the individual chooses not to answer the item.
- **Code 1, missed by 6 days to 1 month:** if the individual's answer is accurate within six days to one month.
- **Code 2, accurate within 5 days:** if the individual's answer is accurate within five days, count current date as day one.

Coding Tip

- In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the individual's response in the margin and go back later to count days if you are unsure whether the date given is within five days.

Examples

1. The date of interview is June 25, 2025. Mr. A, responding to the question, "What month are we in right now?" states that it is June.

   Coding: C0300B would be **coded 2, accurate within five days.**
   Rationale: He correctly stated the month.

2. The date of interview is June 28, 2025 Ms. X, responding to the question, "What month are we in right now?" states that it is July.

   Coding: C0300B would be **coded 2, accurate within five days.**
   Rationale: She correctly stated the month within 5 days, even though the correct month is June. June 2^{8t}h (day 1) + 4 more days is July ^{2n}d, so July is within 5 days of the interview.

3. The date of interview is June 25, 205 Mr. V, responding to the question, "What month are we in right now?" states that it is July.

   Coding: C0300B would be **coded 1, missed by six days to one month**.
   Rationale: He missed the correct month by six days. June 2^{5t}h (day one) + five more days = June 3^{0t}h. Therefore, his answer is incorrect within six days to one month.

4. The date of interview is June 30, 2025. Ms. Q, responding to the question, "What month are we in right now?" states that it is August.

   Coding: C0300B would be **coded 0, missed by more than**

one month. **Rationale:** She missed the month by more than one month.

5. The date of interview is June 2, 2025. Ms. S, responding to the question, "What month are we in right now?" states that it is May.

   Coding: C0300B would be **coded 2, accurate within five days.**
   Rationale: June 2 minus five days = May 2^{9t}h. She correctly stated the month within five days even though the current month is June.

Coding Instructions for C0300C. Able to Report Correct Day of the Week

- **Code 0, incorrect, or no answer:** if the answer is incorrect or the individual chooses not to answer the item.
- **Code 1, correct:** if the answer is correct.

Examples

1. The day of interview is Monday, June 21, 2025.The interviewer asks: "What day of the week is it today?" Ms. N responds, "It's Monday."

   Coding: C0300C would be **coded 1, correct**.
   Rationale: She correctly stated the day of the week.

2. The day of interview is Monday, June 21, 2025. Mr. F, responding to the question, "What day of the week is it today?" states, "Tuesday."

   Coding: C0300C would be **coded 0, incorrect**.
   Rationale: He incorrectly stated the day of the week.

3. The day of interview is Monday, June 21, 2025. Ms. D, responding to the question, "What day of the week is it today?" states, "Today is a good day."

   Coding: C0300C would be **coded 0, incorrect**.
   Rationale: She did not answer the question correctly.

Pediatric Tip:
If applicable, ask the child what date they wrote on their papers that day at school.

C0400: Recall

C0400. Recall	
	Ask individual: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. Enter '-' Dash if unable to assess.
Enter ☐ Code	A. **Able to recall "sock"** 0. **No** – could not recall 1. **Yes, after cueing** ("something to wear") 2. **Yes, no cue required**
Enter ☐ Code	B. **Able to recall "blue"** 0. **No** – could not recall 1. **Yes, after cueing** ("a color") 2. **Yes, no cue required**
Enter ☐ Code	C. **Able to recall "bed"** 0. **No** – could not recall 1. **Yes, after cueing** ("a piece of furniture") 2. **Yes, no cue required**

Item Rationale

Health-related Quality of Life

- Many persons with cognitive impairment can be helped to recall if provided cues.
- Providing memory cues can help maximize individual function and decrease frustration for those individuals who respond.

Planning for Care

- The plan of care should maximize use of cueing for individuals who respond to recall cues. This will enhance independence.

Steps for Assessment

1. Ask the individual the following: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
2. Allow up to five seconds for spontaneous recall of each word.
3. For any word that is not correctly recalled after five seconds, provide a category cue (refer to "Steps for Assessment," for the definition of category cue). Category cues should be used only after the individual is unable to recall one or more of the three words.
4. Allow up to five seconds after category cueing for each missed word to be recalled.

Coding Instructions

For **each** *of the three words the individual is asked to remember:*

- **Code 0, no—could not recall:** if the individual cannot recall the word even after being given the category cue or if the individual responds with a nonsensical answer or chooses not to answer the item.
- **Code 1, yes, after cueing:** if the individual requires the category cue to remember the word.
- **Code 2, yes, no cue required:** if the individual correctly remembers the word spontaneously without cueing.

Coding Tips

- If on the first try (without cueing), the individual names multiple items in a category, one of which is correct, they should be coded as correct for that item.
- If, however, the interviewer gives the individual the cue and the individual then names multiple items in that category, the item is coded as could not recall, even if the correct item was in the list.

Examples

1. Mr. H. is asked to recall the three words that were initially presented. He chooses not to answer the question and states, "I'm tired, and I don't want to do this anymore."

   Coding: C0400A-C0400C would be **coded 0, no—could not recall**, could not recall for each of the three words.
   Rationale: Choosing not to answer a question often indicates an inability to answer the question, so refusals are **coded 0, no—could not recall**. This is the most accurate way to score cognitive function, even though, on occasion, individuals might choose not to answer for other reasons.

2. Mrs. C is asked to recall the three words. She replies, "Socks, shoes, and bed." The examiner then cues, "One word was a color." Mrs. C says, "Oh, the shoes were blue."

   Coding: C0400A, sock, would be **coded 2, yes, no cue required.**
   Rationale: Mrs. C's initial response to the question included "sock." She is given credit for this response, even though she also listed another item in that category (shoes), because she was answering the initial question, without cueing.

   Coding: C0400B, blue, would be **coded 1, yes, after cueing.**
   Rationale: Mrs. C did not recall spontaneously, but did recall after the category cue was given. Responses that include the word in a sentence are acceptable.

   Coding: C0400C, bed, would be **coded 2, yes, no cue required.**
   Rationale: Mrs. C independently recalled the item on the first attempt.

3. Ms. Y is asked to recall the three words. She answers, "I don't remember." The assessor then says, "One word was something to wear." She says, "Clothes." The assessor then says, "OK, one word was a color." She says, "Blue." The interviewer then says, "OK, the last word was a piece of furniture." Ms. Y says, "Couch."

   Coding: C0400A, sock, would be **coded 0, no—could not recall.**
   Rationale: She did not recall the item, even with a cue.

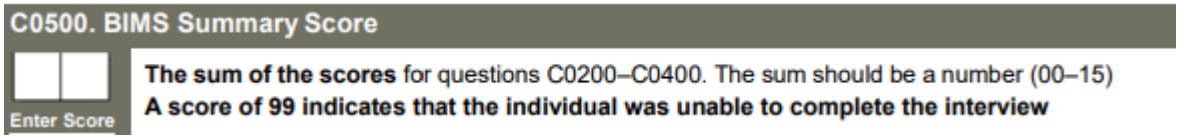
   Coding: C0400B, blue, would be **coded 1, yes, after cueing.**
   Rationale: She did recall after being given the cue.

   Coding: C0400C, bed, would be **coded 0, no—could not recall.**
   Rationale: She did not recall the item, even with a cue.

4. Mr. D is asked to recall the three words. He says, "I don't remember." The interviewer then says, "One word was something to wear." Mr. D says, "Hat, shirt, pants, socks, shoe, belt."

   Coding: C0400A, sock, would be **coded 0, no—could not recall.**
   Rationale: After getting the category cue, Mr. D named more than one item (That is, a laundry list of items) in the category. His response is coded as incorrect, even though one of the items was correct, because he did not demonstrate recall and likely named the item by chance.

C0500: BIMS Summary Score



Item Rationale

Health-related Quality of Life

- The total score:
  - Allows comparison with future and past performance.
  - Decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.

- Provides caregiver with a more reliable estimate of individual function and allows caregiver interactions with individuals that are based on more accurate impressions about individual ability.

Planning for Care

- The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment. A diagnosis of dementia should only be made after a careful assessment for other reasons for impaired cognitive performance. The final determination of the level of impairment should be made by the individual's physician or mental health care specialist; however, these practitioners can be provided specific BIMS results and the following guidance:

The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where individuals can hear all questions and the individual is not delirious suggest the following distributions:

- 13-15: cognitively intact
- 8-12: moderately impaired
- 0-7: severe impairment
- Abrupt changes in cognitive status (as indicative of delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
- Plan of care can be more individualized based upon reliable knowledge of individual function.

Step for Assessment

After completing C0200-C0400:

1. This field will be auto populated based on the responses to all questions from C0200 through C0400.

Coding Instructions

The total possible BIMS score ranges from 00 to 15

- If the individual chooses not to answer a specific question(s) that question is coded as incorrect and the item(s) counts in the total score. If, however, the individual chooses not to answer four or more items, then the interview is coded as incomplete and the Caregiver Assessment (C0600) is completed.
- To be considered a completed interview, the individual had to attempt to provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct.

Coding Tips

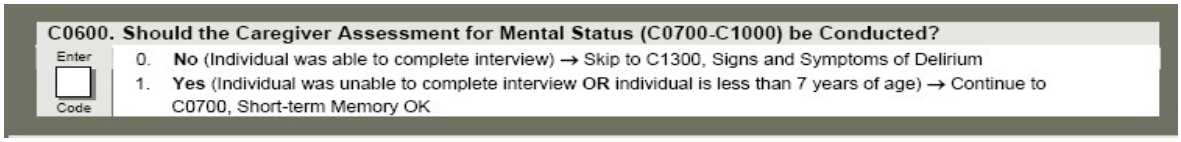
- Occasionally, an individual can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview. Code a (-) dash for C0500, Summary Score, and complete the Caregiver Assessment (C0600).

Example

1. Mrs. E's scores on items C0200-C0400 were as follows:
   - C0200 (repetition) 3
   - C0300A (year) 2
   - C0300B (month) 2
   - C0300C (day) 1
   - C0400A (recall "sock") 2
   - C0400B (recall "blue") 2
   - C0400C (recall "bed") 0

   Coding: C0500 would be **coded 12**.

C0600: Should the Caregiver Assessment for Mental Status (C0700- C1000) Be Conducted?



Item Rationale

Health-related Quality of Life

- Direct or performance-based testing of cognitive function using the BIMS is preferred as it decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium. However, a minority of individuals are unable or unwilling to participate in the BIMS.
- Mental status can vary among persons unable to communicate or who do not complete the interview.
  - Therefore, report of observed behavior is needed for persons unable to complete the BIMS interview.
  - When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, activities, and therapies may not be offered.

Planning for Care

- Abrupt changes in cognitive status (as indicative of delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
  - This remains true for persons who are unable to communicate or to complete the BIMS.
- Specific aspects of cognitive impairment, when identified, can direct caregiver interventions to facilitate greater independence and function.

Step for Assessment

1. Review whether **Summary Score** item (C0500), is **coded 99**, unable to complete interview.

Coding Instructions

- **Code 0, no:** if the BIMS was completed and scored between 00 and 15. Skip to C1310.
- **Code 1, yes:** if the individual chooses not to participate in the BIMS or if four or more items were coded 0 because chose not to answer or gave a nonsensical response resulting in a score of 99. Also code 1, yes if the individual is less than seven years of age. Continue to C0700-C1000 to perform the Caregiver Assessment for Mental Status.

Coding Tip

- If an individual is scored 00 on C0500, C0700-C1000, Caregiver Assessment, should not be completed. **00** is a legitimate value for C0500 and indicates that the interview was complete. To have an incomplete interview, the individual had to choose not to answer or had to give completely unrelated, nonsensical responses to four or more BIMS items resulting in a score of 99 on C0500.

C0700-C1000: Caregiver Assessment of Mental Status Item

Caregiver Assessment for Mental Status	
Do not conduct if Brief Interview for Mental Status (C0200–C0500) was completed	
C0700. Short-term Memory OK	
Enter ☐ Code	**Seems or appears to recall after 5 minutes.** Enter '-' Dash if unable to assess OR individual is less than 2 years of age. 0. Memory OK 1. Memory problem
C0800. Long-term Memory OK	
Enter ☐ Code	**Seems or appears to recall long past.** Enter '-' Dash if unable to assess OR individual is less than 2 years of age. 0. Memory OK 1. Memory problem
C0900. Memory/Recall Ability	
↓ Check all that the individual was normally able to recall	
☐	A. Current season
☐	B. Location of own room
☐	C. Caregiver names and faces
☐	D. That he or she is in their own home/room
☐	Z. None of the above were recalled
C1000. Cognitive Skills for Daily Decision Making	
Enter ☐ Code	**Made decisions regarding tasks of daily life** 0. **Independent** – decisions consistent/reasonable 1. **Modified independence** – some difficulty in new situations only 2. **Moderately impaired** – decisions poor; cues/supervision required 3. **Severely impaired** – never/rarely made decisions

Item Rationale

Health-related Quality of Life

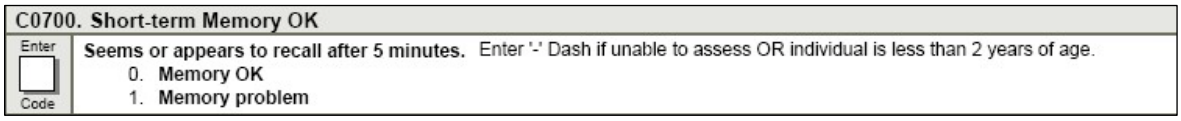
- Cognitive impairment is prevalent among some groups of individuals.
- Many persons with memory problems can function successfully in a structured, routine environment.
- Individuals may appear to be cognitively impaired because of communication challenges or lack of interaction but may be cognitively intact.
- When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities, and therapies may not be offered.

Planning for Care

- Abrupt changes in cognitive status (as indicative of delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.

- The level and specific areas of impairment affect daily function and care needs. By identifying specific aspects of cognitive impairment, caregiver interventions can be directed toward facilitating greater function.
- Probing beyond first, perhaps mistaken, impressions is critical to accurate assessment and appropriate plan of care.

C0700: Short-term Memory OK



Item Rationale

Health-related Quality of Life

- To assess the mental state of individuals who cannot be interviewed, an intact five minute recall ("short-term memory OK") indicates greater likelihood of normal cognition.
- An observed "memory problem" should be taken into consideration in Planning for Care.

Planning for Care

- Identified memory problems typically indicate the need for:
  - Assessment and treatment of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect,
  - Possible evaluation for other problems with thinking,
  - Additional caregiver support,
  - At times frequent prompting during daily activities; or
  - Additional support during recreational activities.

Steps for Assessment

1. Determine the individual's short-term memory status by asking him or her:
   - To describe an event 5 minutes after it occurred if you can validate the individual's response; or
   - To follow through on a direction given five minutes earlier.
2. Nurse assessor should observe how often the individual has to be re-oriented to an activity or instructions.
3. The nurse assessor also should observe the individual's cognitive function in varied daily activities, if possible.
4. Observations should be made by the caregiver and others with close contact with the individual.
5. Ask the caregiver and family or significant others about the individual's short-term memory status.
6. Review the medical record, if available, for clues to the individual's short-term memory during the look-back period.

Coding Instructions

Based on all information collected regarding the individual's short-term memory during the 7-day look-back period, identify and code according to the most representative level of function.

- **Code 0, memory OK:** if the individual recalled information after five minutes.
- **Code 1, memory problem:** if the most representative level of function shows the absence of recall after five minutes.
- **Code "-", Dash:** if unable to assess or if the individual is less than two years of age.

Coding Tip

If the test cannot be conducted (individual will not cooperate, is non-responsive, etc.) and caregivers were unable to make a determination based on observing the individual, use the standard "no information" code (a dash, "**-**") to indicate that the information is not available because it could not be assessed.

Example

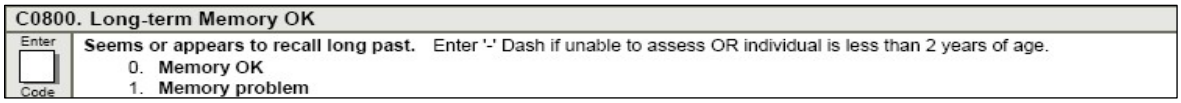
1. Ms. G has just finished playing bingo with her caregiver. You ask her if she enjoyed herself playing bingo, but she returns a blank stare**.** When you ask her if she was just playing bingo, she says, "no." **Code 1, memory problem.**

   Coding: C0700 would be **coded 1, memory problem.**
   Rationale: Ms. G could not recall an event that took place within the past 5 minutes.

Pediatric Tip:

- This field is dashable. A dash means no information, or unable to assess/determine.
- If the child is less than two years old code this with a dash; do not ask the parent/caregiver. For a child two years old or greater, use nursing judgment to determine whether to ask the caregiver about the child's short-term memory, or code as a dash.

C0800: Long-term Memory OK



Item Rationale

Health-related Quality of Life

- An observed "long-term memory problem" should be taken into consideration in Planning for Care.

Planning for Care

- Long-term memory problems indicate the need for:
  - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect; or
  - Possible evaluation for other problems with thinking
  - Additional caregiver support during daily activities or recreational activities.

Steps for Assessment

1. Determine individual's long-term memory status by engaging in conversation, reviewing memorabilia (photographs, memory books, keepsakes, videos, or other recordings that are meaningful to the individual) with the individual or observing response to family.

2. Ask questions for which you can validate the answers from review of the medical record, if available, general knowledge, the individual's family, etc.
    - Ask the individual, "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?"
3. Observe if the individual responds to memorabilia or family members.
4. Observations should be made by caregivers and others with close contact with the individual.
5. Ask the caregiver and family or significant others about the individual's memory status.
6. Review the medical record, if available, for clues to the individual's long-term memory during the look-back period.

Coding Instructions

- **Code 0, memory OK:** if the individual accurately recalled long past information.
- **Code 1, memory problem:** if the individual did not recall long past information or did not recall it correctly.
- **Code "-", Dash:** if unable to assess or if the individual is less than two years of age.

Coding Tip

- If the test cannot be conducted (individual will not cooperate, is non-responsive, etc.) and caregivers were unable to make a determination based on observation of the individual, use the standard "no information" code (a dash, "-"), to indicate that the information is not available because it could not be assessed.

Pediatric Tip:

- If the child is less than two years old code this with a dash; do not ask the parent/caregiver. For a child two years old or greater, use nursing judgment to determine whether to ask the caregiver about the child's long-term memory or code as a dash.

C0900: Memory/Recall Ability

C0900. Memory/Recall Ability	
↓ Check all that the individual was normally able to recall	
☐	A. Current season
☐	B. Location of own room
☐	C. Caregiver names and faces
☐	D. That he or she is in their own home/room
☐	Z. None of the above were recalled

Item Rationale

Health-related Quality of Life

- An observed "memory/recall problem" with these items may indicate:
    - Cognitive impairment and the need for additional support with reminders to support increased independence; or
    - Delirium, if this represents a change from the individual's baseline.

Planning for Care

- An observed "memory/recall problem" with these items may indicate the need for:
    - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect; or

- Possible evaluation for other problems with thinking
- Additional signs, directions, pictures, verbal reminders to support the individual's independence,
- An evaluation for acute delirium if this represents a change over the past few days to weeks,
- An evaluation for chronic delirium if this represents a change over the past several weeks to months,
- Additional caregiver support; or
- The need for emotional support, reminders and reassurance to reduce anxiety and agitation.

Steps for Assessment

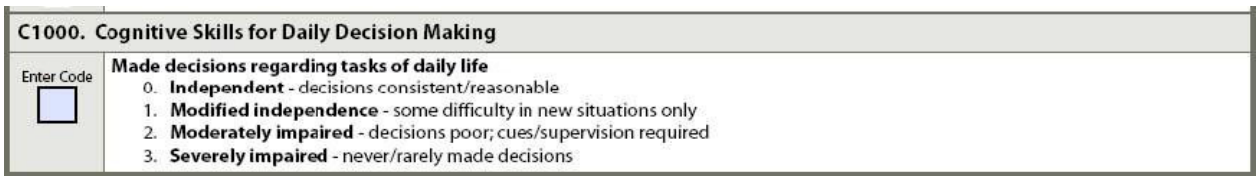
1. Ask the individual about each item. For example, "What is the current season? Is it fall, winter, spring, or summer?" "Where are we?" If the individual is not in his or her room, ask, "Will you show me to your room?" Observe the individual's ability to find the way.
2. For individuals with limited communication skills, to determine the most representative level of function, ask the caregiver and family or significant other about recall ability.
   - Ask whether the individual gave indications of recalling these subjects or recognizing them during the look-back period.
3. Observations should be made by caregivers and others with close contact with the individual.
4. Review the medical record, if available, for indications of the individual's recall of these subjects during the look-back period.

Coding Instructions

For each item that the individual recalls, check the corresponding answer box. If the individual recalls none, check ***none of above.***

- **Check C0900A, current season:** if individual is able to identify the current season (For example, correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).
- **Check C0900B, location of own room:** if individual is able to locate and recognize own room. The individual should be able to find the way to the room.
- **Check C0900C, caregiver names and faces:** if individual is able to distinguish a caregiver from family members, strangers, visitors, and other individuals. It is not necessary for the individual to know the caregiver's name, but he or she should recognize that the person is a caregiver and not the individual's son or daughter, etc.
- **Check C0900D, that he or she is in their own home/room:** if individual is able to determine that he or she is currently living in his or her own home.
- **Check C0900Z, none of above was recalled.**

C1000: Cognitive Skills for Daily Decision Making



Definitions

- **Daily Decision Making** – Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (For example, clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (That is, not repetitively) from others to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (For example, ask for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.

Item Rationale

Health-related Quality of Life

- An observed "difficulty with daily decision making" may indicate:
  - underlying cognitive impairment and the need for additional coaching and support; or
  - possible anxiety or depression.

Planning for Care

- An observed "difficulty with daily decision making" may indicate the need for:
  - a more structured plan for daily activities and support in decisions about daily activities,
  - encouragement to participate in structured activities; or
  - an assessment for underlying delirium and medical evaluation.

Steps for Assessment

1. Review the medical record, if available. Consult family members and caregivers. Observe the individual.
2. Observations should be made by caregivers and others with close contact with the individual.
3. The intent of this item is to record what the individual is doing (performance). Focus on whether or not the individual is actively making these decisions and not whether the caregiver believes the individual might be capable of doing so.
4. Focus on the individual's actual performance. Where a caregiver takes decision-making responsibility away from the individual regarding tasks of everyday living, or the individual does not participate in decision making, whatever his or her level of capability may be, the individual should be coded as impaired performance in decision making.

Coding Instructions

Record the individual's actual performance in making everyday decisions about tasks or activities of daily living. Enter one number that corresponds to the most correct response.

- **Code 0, independent:** if the individual's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture, values.
- **Code 1, modified independence:** if the individual organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations.
- **Code 2, moderately impaired:** if the individual's decisions were poor; the individual required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
- **Code 3, severely impaired:** if the individual's decision making was severely impaired; the individual never (or rarely) made decisions.

Coding Tips

- If the individual "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item C1000 would be **coded 3, severely impaired**. If the individual makes decisions, although poorly, **code 2, moderately impaired**.
- An individual's considered decision to exercise his or her right to decline treatment or recommendations by interdisciplinary team members should **not** be captured as impaired decision making in Item C1000, **Cognitive Skills for Daily Decision Making**.

Examples

1. Mr. B. seems to have severe cognitive impairment and is non-verbal. He usually clamps his mouth shut when offered a bite of food.
2. Mrs. C. does not generally make conversation or make her needs known, but replies "yes" when asked if she would like to take a nap.

   Coding: For the examples listed in 1A and 1B, Item C1000 would be **coded 3, severe impairment.**
   Rationale: In both examples, the individuals are primarily non-verbal and do not make their needs known, but they do give basic verbal or non-verbal responses to simple gestures or questions regarding care routines. More information about how the individuals function in the environment is needed to definitively answer the questions. From the limited information provided it appears that their communication of choices is limited to very particular circumstances, which would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week on the MN/LOC. If such decisions are more frequent or involved more activities, the individual may be only moderately impaired or better.

3. Mrs. J makes her own decisions throughout the day and is consistent and reasonable in her decision-making except that she constantly walks away from the walker she has been using for nearly 2 years. Asked why she doesn't use her walker, she replies, "I don't like it. It gets in my way, and I don't want to use it even though I know you think I should."

   Coding: C1000 would be **coded 0, independent.**
   Rationale: Mrs. J is making and expressing understanding of her own decisions, and her decision is to decline the recommended course of action – using the walker. Other decisions she made throughout the look-back period were consistent and reasonable.

4. Mrs. C. routinely enjoys having coffee with her friends on Wednesday mornings in her home, and often does not need a reminder. Due to renovations, however, the meeting place was moved to another room in the home. Mrs. C was informed of this change and was accompanied to the new room by her caregiver. The caregiver noticed that Mrs. C. was uncharacteristically agitated and unwilling to engage with other individuals or the caregiver. She eventually left and was found sitting in the original room. Asked why she came back to this location, she responded, "you brought me to the wrong room, I'll wait here for my coffee."

   Coding: C1000 would be **coded 1, modified independent.**
   Rationale: The individual is independent under routine circumstances. However, when the situation was new or different, she had difficulty adjusting.

5. Mr. G. enjoys meals with his family members. Recently, he has started to lose weight. He appears to have little appetite, rarely eats without reminders and willingly gives his food to others at the

table. Mr. G. requires frequent cueing from his caregiver to eat and supervision to prevent him from sharing his food.

Coding: C1000 would be **coded 2, moderately impaired.**
Rationale: Mr. G is making poor decisions by giving his food away. He requires cueing to eat and supervision to be sure that he is eating the food on his plate.

Pediatric Tip:

- When asking the caregiver this question, focus on whether or not the child is actually making these decisions, not whether or not they are capable.
- Example: Code 3, Severely impaired, for infants and toddlers and for any child when the parent/caregiver has assumed all responsibility for daily decisions.

C1310: Signs and Symptoms of Delirium (from CAM©)

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)

Code after completing Brief Interview for Mental Status or Caregiver Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code ☐ **Is there evidence of an acute change in mental status** from the individual's baseline?"
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

☐ **B. Inattention** - Did the individual have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ **C. Disorganized Thinking** - Was the individual's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ **D. Altered Level of Consciousness** - Did the individual have altered level of consciousness, as indicated by any of the following criteria?
- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.

Definitions

- **Delirium** – A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.
- **Inattention** – Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Individual seems unaware or out of touch with environment (For example, dazed, fixated or darting attention).
- **Fluctuation** – The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look-back period. Fluctuating behavior may be noted by the interviewer, reported by the caregiver or family or documented in the medical record.
- **Disorganized Thinking** – Evidenced by rambling, irrelevant, or incoherent speech.
- **Altered Level of Consciousness** –
  - **Vigilant** – startles easily to any sound or touch.
  - **Lethargic –** repeatedly dozes off when you are asking questions, but responds to voice or touch.
  - **Stupor –** very difficult to arouse and keep aroused for the interview.
  - **Comatose –** cannot be aroused despite shaking and shouting.

Item Rationale

Health-related Quality of Life

- Delirium is associated with:
  - increased mortality,
  - functional decline,
  - development or worsening of incontinence,
  - behavior problems,
  - withdrawal from activities, and/or
  - re-hospitalizations and increased length of nursing facility stay.

Health-related Quality of Life (Continued)

- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.

Planning for Care

- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection is essential to identify and treat or eliminate the cause.

Steps for Assessment

1. Observe individual behavior during the **BIMS** items (C0200-C0400) for the signs and symptoms of delirium.
2. If the **Caregiver Assessment for Mental Status** items (C0700-C1000) was completed instead of the BIMS, ask the caregiver about their observations of signs and symptoms of delirium.
3. Review medical record documentation, if available, to determine the individual's baseline status, fluctuations in behavior, and behaviors that might have occurred during the 7 day look-back period that were not observed during the BIMS.
4. Interview the caregiver, family members and others in a position to observe the individual's behavior during the 7 day look-back period.

Coding Instructions for C1310A, Acute Mental Status Change

- **Code 0, no:** if there is no evidence of acute mental status change from the individual's baseline.
- **Code 1, yes:** if the individual has an alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline.

Examples

1. Nurse is completing an initial assessment for Mr. S. His family reports that there has been a change and that just four days ago he was alert and oriented. During the BIMS interview, Mr. S is lethargic and incoherent.
   Coding: C1310A would be **coded 1, yes**
   Rationale: There is an acute change in the individua"s behavior from alert and oriented (family report) to lethargic and incoherent during interview.

2. Mrs. G has poor short-term memory and disorientation to time. She suddenly becomes agitated, calling out to her dead husband, tearing off her clothes, and being completely disoriented to time, person, and place.
   Coding: C1310A would be **coded 1, yes**
   Rationale: The new behaviors represent an acute change in mental status.

Other Examples of Acute Mental Status Changes

- An individual who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
- An individual who is normally quiet and content suddenly becomes restless or noisy.
- An individual who is usually able to find his way around his apartment complex suddenly begins to get lost.

Coding Instructions for C1310B, Inattention

- **Code 0, behavior not present:** if the individual remains focused during the interview and all other sources agree that the individual was attentive during other activities.
- **Code 1, behavior continuously present, did not fluctuate:** if the individual had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary during the look-back period. All sources must agree that inattention was consistently present to select this code.
- **Code 2, behavior present, fluctuates:** if inattention is noted during the interview or any source reports that the individual had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied during interview or during the look-back period or if information sources disagree in assessing level of attention.

Examples

1. Ms. M tries to answer all questions during the BIMS. Although she answers several items incorrectly and responds "I don't know" to others, she pays attention to the interviewer. Caregiver and medical records, if available, indicate that this is her consistent behavior.

   Coding: Item C1310B would be **coded 0, behavior not present.**
   Rationale: Ms. M remained focused throughout the interview and this was constant during the look-back period.

2. Questions during the BIMS must be frequently repeated because Ms. P's attention wanders. This behavior occurs throughout the interview and medical records, if available, agree that this behavior is consistently present. Ms. P has a diagnosis of dementia.

   Coding: Item C1310B would be **coded 1, behavior continuously present, does not fluctuate.**

   Rationale: Ms. P's attention consistently wandered throughout the 7 day look- back period. Ms. P's dementia diagnosis does not affect the coding.

3. During the BIMS interview, Mr. R was not able to focus on all questions asked and his gaze wandered. However, several notes in his medical record, if available, indicate that he was attentive when the caregiver communicated with him.

Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**
Rationale: Evidence of inattention was found during the BIMS but was noted to be absent in the medical record. This disagreement shows possible fluctuation in the behavior.

4. Mrs. Y is dazedly staring at the television for the first several questions. When you ask a question, she looks at you momentarily but does not answer. Midway through questioning, she seems to pay more attention and tries to answer.

   Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**
   Rationale: Mrs. Y's attention fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2.**

Pediatric Tip:
Code Inattention if present, even if age appropriate.

Coding Instructions for C1310C, Disorganized Thinking

- **Code 0, behavior not present:** if all sources agree that the individual's thinking was organized and coherent, even if answers were inaccurate or wrong.
- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the individual's responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the individual unpredictably switched from subject to subject.
- **Code 2, behavior present, fluctuates:** if, during the interview or according to other data sources, the individual's responses fluctuated between disorganized/incoherent and organized/clear. Also code as fluctuating if information sources disagree.

Examples

1. The interviewer asks Mr. U, who is often confused, to give the date, and the response is: "Let's go get the sailor suits!" He continues to provide irrelevant or nonsensical responses throughout the interview, and the caregiver indicates this is constant.
   Coding: C1310C would be coded **1, behavior continuously present, does not fluctuate**.
   Rationale: All sources agree that the disorganized thinking is constant.

2. Mrs. A responds that the year is 1987 when asked to give the date. The medical record, if available and caregiver indicate that Mrs. A is never oriented to time but has coherent conversations.

   Coding: C1310C would be **coded 0, behavior not present.**
   Rationale: Mrs. A's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

3. Ms. C was able to tell the interviewer her name, the year and where she was. She was able to talk about the activity she just attended and the individuals and caregiver that also attended. Then she suddenly asked the interviewer, "Who are you? What are you doing in my daughter's home?"

   Coding: C1310C would be **coded 2, behavior present, fluctuates.**
   Rationale: Ms. C's thinking fluctuated between coherent and incoherent at least once. If as few as one source notes fluctuation, then the behavior should be **coded 2**.

Coding Instructions for C1310D, Altered Level of Consciousness

- **Code 0, behavior not present:** if all sources agree that the individual was alert and maintained wakefulness during conversation, interview(s), and activities.
- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the individual was consistently lethargic (difficult to keep awake), stuporous (very difficult to arouse and keep aroused), vigilant (startles easily to any sound or touch), or comatose.
- **Code 2, behavior present, fluctuates:** if, during the interview or according to other sources, the individual varied in levels of consciousness. For example, was at times alert and responsive, while at other times the individual was lethargic, stuporous, or vigilant. Also code as fluctuating if information sources disagree.

Coding Tip

- A diagnosis of coma or stupor is not needed for the caregiver to note the behavior in this section.

Examples

1. Ms. D is alert and conversational and answers all questions during the BIMS interview, although not all answers are correct. Medical record documentation, if available, and caregiver report during the 7-day look-back period consistently noted that Ms. D was alert.

   Coding: C1310D would be coded 0, behavior not present.
   Rationale: All evidence indicates that the Ms. D is alert during conversation, interview(s) and activities.

2. Ms. E is lying in bed. She arouses to soft touch but is only able to converse for a short time before her eyes close, and she appears to be sleeping. Again, she arouses to voice or touch but only for short periods during the interview. Information from other sources indicates that this was her condition throughout the look-back period.

   Coding: C1310D would be **coded 1, behavior continuously present, does not fluctuate.**
   Rationale: The individual's lethargy was consistent throughout the interview, and there is consistent documentation of lethargy in the medical record during the look-back period.

3. Mr. H is usually alert, oriented to time, place, and person. Today, at the time of the BIMS interview, he is conversant at the beginning of the interview. Towards the end of the interview he becomes lethargic but responds to voice.

   Coding: C1310D would be **coded 2, behavior present, fluctuates.**
   Rationale: The level of consciousness fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2, fluctuating**.

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of: Item A = 1 **OR**
Item B, C or D = 2, **AND** Item B = 1 or 2 **AND EITHER** Item C = 1 or 2 OR Item D = 1 OR 2

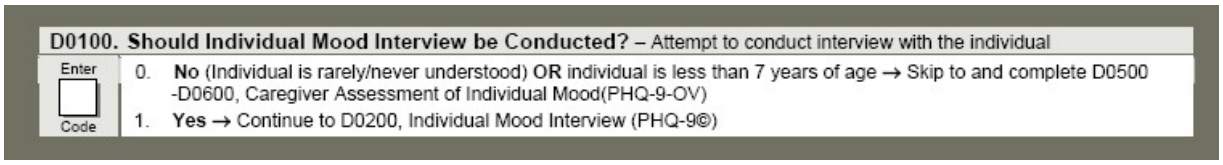
SECTION D: MOOD

Intent: The items in this section address mood distress, a serious condition that is under- diagnosed and under treated is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress because these signs and symptoms can be treatable.

It is important to note that coding the presence of indicators in Section D does not automatically mean that the individual has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D, they simply record the presence or absence of specific clinical mood indicators. These indicators should be considered when developing the individual's plan of care.

- Depression can be associated with:
  - psychological and physical distress (For example, poor adjustment to a new setting, loss of independence, chronic illness, increased sensitivity to pain),
  - decreased participation in therapy and activities (For example, caused by isolation),
  - decreased functional status (For example, resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and
  - poorer outcomes (For example, decreased appetite, decreased cognitive status).
- Findings suggesting mood distress should lead to:
  - identifying causes and contributing factors for symptoms,
  - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and
  - ensuring an individual's safety.

D0100: Should Individual Mood Interview Be Conducted?



If the individual is less than 7 years of age, skip to and complete D0500–- D0600, Caregiver Assessment of Individual Mood (PHQ-9-OV).

Item Rationale

This item helps to determine whether or not an individual or caregiver interview should be conducted.

Health-related Quality of Life

- Most individuals who can communicate are able to answer questions about how they feel.
- Obtaining information about mood directly from the individual, sometimes called "hearing the individual's voice," is more reliable and accurate than observation alone for identifying a mood disorder.

Planning for Care

- Symptom-specific information from direct individual interviews will allow for the incorporation of the individual's voice in the individualized care plan.
- If an individual cannot communicate, then **Caregiver Mood Interview** (D0500 A-J) should be conducted.

Steps for Assessment

1. Review **Makes Self Understood** item (B0700) to determine if the individual is understood at least sometimes (B0700 = 0, 1, or 2).
2. Review **Language** item (A1100) to determine if the individual needs or wants an interpreter to communicate with doctors or health caregivers (A1100 = 1).
    - If the individual needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

- **Code 0, no:** if the interview should not be conducted. This option should be selected for individuals who are coded as rarely/never understood in item B0700, Makes Self Understood (B0700 = 3), or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, **Caregiver Assessment of Individual Mood** (PHQ-9-OV©)
- **Code 1, yes:** if the individual interview should be conducted. This option should be selected for individuals who are coded as understood, usually understood, or sometimes understood in item B0700, Makes Self Understood (B0700 = 0, 1 or 2), and for whom an interpreter is not needed or is present. Continue to item D0200, **Individual Mood Interview** (PHQ-9©).

Pediatric Tip

If the child is less than seven years old skip to D0500. If the child is seven years old or greater, use nursing judgment to determine whether to complete this section or skip to D0500 (**Caregiver Assessment of Mood**).

D0200: Individual Mood Interview (PHQ-9©)

(14-Day Look-Back)

D0200. Individual Mood Interview (PHQ-9©)

Say to individual: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the individual: "*About **how often** have you been bothered by this?*"
Read and show the individual a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2–6 days** (several days)
2. **7–11 days** (half or more of the days)
3. **12–14 days** (nearly every day)

		1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes ↓	
A.	*Little interest or pleasure in doing things*	☐	☐
B.	*Feeling down, depressed, or hopeless*	☐	☐
C.	*Trouble falling or staying asleep, or sleeping too much*	☐	☐
D.	*Feeling tired or having little energy*	☐	☐
E.	*Poor appetite or overeating*	☐	☐
F	*Feeling bad about yourself – or that you are a failure or have let yourself or your family down*	☐	☐
G.	*Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H.	*Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I.	Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐

Definitions:

- **9-Item Patient Health Questionnaire (PHQ-9c)** – A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

Item Rational

Health-related Quality of Life

- Depression can be associated with:
  - Psychological and physical distress,
  - Decreased participation in therapy and activities,
  - Decreased functional status, and
  - Poorer outcomes.
- Mood disorders are often under-diagnosed and under treated.

Planning for Care

- Findings suggesting mood distress could lead to:
  - Identifying causes and contributing factors for symptoms and
  - Identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms.

Steps for Assessment

Look-back period for this item is 14 days.

1. Explain the reason for the interview before beginning.
   - **Suggested language:** "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help assure that you receive better care." Conduct the interview in a private setting.
2. If an interpreter is used during individual interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the individual's responses. Interpreters are people who translate oral or written language from one language to another.
3. Sit so that the individual can see your face. Minimize glare by directing light sources away from the individual's face.
4. Be sure the individual can hear you.
5. Individuals with a hearing impairment should be tested using their usual communication devices/techniques, as applicable.
6. Try an external assistive device, if available, (headphones or hearing amplifier) if you have any doubt about hearing ability.
7. Minimize background noise.
8. If you are administering the PHQ-9© in paper form, be sure that the individual can see the print. Provide large print or assistive device (For example, page magnifier) if necessary.
9. Explain and /or show the interview response choices. A cue card with the response choices clearly

written in large print might help the individual comprehend the response choices.

- **Suggested language:** "I am going to ask you how often you have been bothered by a particular problem over the last two weeks. I will give you the choices that you see on this card." (Say while pointing to cue card): "0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."

10. Interview the individual.
    - **Suggested language:** "Over the last two weeks, have you been bothered by any of the following problems?"
    - Then, for each question in **Individual Mood Interview**
        - Read the item as it is written.
        - Do not provide definitions because the meaning **must be** based on the individual's interpretation. For example, the individual defines for himself what "tired" means; the item should be scored based on the individual's interpretation.
        - Each question **must be** asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
        - Enter code 9 for any response that is unrelated, incomprehensible, or incoherent or if the individual's response is not informative with respect to the item being rated; this is considered a nonsensical response (For example, when asked the question about "poor appetite or overeating," the individual answers, "I always win at poker").
        - For a yes response, ask the individual to tell you how often he was bothered by the symptom over the last 14 days. Use the response choices in D0200 Column 2, Symptom Frequency. Start by asking the individual the number of days that he was bothered by the symptom and read and show cue card with frequency categories/descriptions (0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day).

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if the individual indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
- **Code 1, yes:** if the individual indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9, no response:** if the individual was unable or chose not to complete the assessment, responded nonsensically and/or the interviewer was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.

Coding Instructions for Column 2. Symptom Frequency

Record the individual's responses as they are stated, regardless of whether the individual or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.

- **Code 0, never or 1 day:** if the individual indicates that he or she has never or has only experienced the symptom on one day.
- **Code 1, 2-6 days (several days):** if the individual indicates that he or she has experienced the symptom for 2-6 days.

- **Code 2, 7-11 days (half or more of the days):** if the individual indicates that he or she has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if the individual indicates that he or she has experienced the symptom for 12-14 days.

Coding Tips and Special Populations

- For question D0200I, Thoughts That You Would Be Better Off Dead/Hurting Yourself in Some Way:
  - The checkbox in item D0350 reminds the assessor to notify a responsible clinician (psychologist, physician, etc.). Follow community protocol for evaluating possible self- harm.
  - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the individual or may feel that the question is too personal. Others may worry that it will give the individual inappropriate ideas. However,
    - Experienced interviewers have found that most individuals who are having this feeling appreciate the opportunity to express it.
    - Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the individual is already feeling.
    - The best interviewing approach is to ask the question openly and without hesitation.
- If the individual uses his own words to describe a symptom, this should be briefly explored. If you determine that the individual is reporting the intended symptom but using his own words, ask him to tell you how often he was bothered by that symptom.
- Select only one frequency response per item. If the individual has difficulty selecting between two frequency responses, code for the higher frequency.
- Some items (For example, item F) contain more than one phrase. If an individual gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Individuals may respond to questions:
  - Verbally,
  - By pointing to their answers on the cue card; or
  - By writing out their answers.

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some individuals may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
  - **Example:** Say, "That's interesting, now I need to know…"; "Let's get back to…"; "I understand, can you tell me about…."

Interviewing Tips and Techniques (Continued)

- Validate your understanding of what the individual is saying by asking for clarification.
  - **Example:** Say, "I think I hear you saying that…"; "Let's see if I understood you correctly."; "You said…. Is that right?"
- If the individual has difficulty selecting a frequency response, start by offering a single frequency

response and follow with a sequence of more specific questions. This is known as unfolding.

- **Example:** Say, "Would you say [name symptom] bothered you more than half the days in the past two weeks?"
  - If the individual says "yes," show the cue card and ask whether it bothered her nearly every day (12-14 days) or on half or more of the days (7-11 days).
  - If the individual says "no," show the cue card and ask whether it bothered her several days (2-6 days) or never or one day (0-1 day).

- Noncommittal responses such as "not really" should be explored. Individuals may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered them, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:
  - "What do you mean?"
  - "Tell me what you have in mind."
  - "Tell me more about that."
  - "Please be more specific."
  - "Give me an example."
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
  - **Example:** Item D0200A, **Little Interest or Pleasure in Doing Things**. The individual, when asked how often he or she has been bothered by little interest or pleasure in doing things, responds, "There's nothing to do here, all you do is eat, bathe, and sleep. They don't do anything I like to do."
    - Possible interview response: "You're saying there isn't much to do here and I want to come back later to talk about some things you like to do. Thinking about how you've been feeling over the past two weeks, how often have you been bothered by little interest or pleasure in doing things."
  - **Example:** Item D0200B, **Feeling Down, Depressed, or Hopeless**. The individual, when asked how often he or she has been bothered by feeling down, depressed, or hopeless, responds: "How would you feel if you had to leave your home?"
    - Possible interview response: "You asked how I would feel, but it is important that I understand **your** feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last two weeks?"
- If the individual has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if an individual has moderate cognitive impairment but can respond to simple, direct questions.
  - **Example: Item D0200C, Trouble Falling or Staying Asleep, or Sleeping Too Much.**
    - You can break the item down as follows: "How often are you having problems falling asleep?" (pause for response) "How often are you having problems staying asleep?" (pause for response) "How often do you feel you are sleeping too much?"
  - **Example**: Item D0200E, **Poor Appetite or Overeating.** The individual responds "the food is always cold and it just doesn't taste like it does at home. The doctor won't let me have any

salt."

- You can simplify this item by asking: "In the last two weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?"
- Possible interviewer response: "You're telling me the food isn't what you eat at home and you can't add salt. How often would you say that you were bothered by poor appetite or over-eating during the last two weeks?"

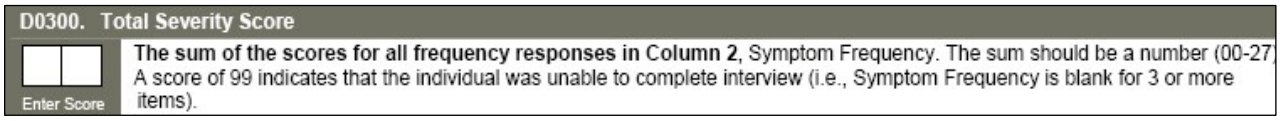
- **Example: Item D0200H, Moving or Speaking So Slowly That Other People Could Have Noticed. Or the Opposite—Being So Fidgety or Restless That You Have Been Moving Around a Lot More than Usual.**
  - You can simplify this item by asking: "How often are you having problems with moving or speaking so slowly that other people could have noticed?" (pause for response) "How often have you felt so fidgety or restless that you move around a lot more than usual?"

Pediatric Tips

Complete this section only if the child is seven years old or greater and able to respond to the questions. You can get parent/caregiver input to these questions even when interviewing the child, especially for F, G, H, and I and for Symptom Frequency. However, if 50 percent or more of the information is obtained from the parent/caregiver then switches to conducting the Caregiver Assessment of Mood, D0400.

- D0200F Ask the child "Do you like yourself?"
- D0200I Ask the child "Do you ever feel like hurting yourself on purpose?"

D0300: Total Severity Score



Definitions

- **Total Severity Score -** A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Item Rationale

Health-related Quality of Life

- The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the individual's physician, other clinicians and mental health specialists for appropriate follow up.
- The **Total Severity Score** is a summary of the frequency scores on the PHQ-9© that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessment by providers or mental health specialists.

Planning for Care

- The PHQ-9© **Total Severity Score** also provides a way for health care providers and clinicians to easily identify and track symptoms and how they are changing over time.

Steps for Assessment

After completing D0200 A-I:

1. Add the numeric scores across all frequency items in **Individual Mood Interview** (D0200) Column 2.
2. Do not add up the score while you are interviewing the individual. Instead, focus your full attention on the interview.
3. The maximum score is 27 (9 × 3).

Coding Instructions

- The interview is successfully completed if the individual answered the frequency responses of at least seven of the nine items on the PHQ-9©.
- If symptom frequency is blank for three or more items, the interview is deemed **NOT** complete. **Total Severity Score** should be coded as "99" and the **Caregiver Assessment of Mood** should be conducted.
- Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27** (or "**99**" if symptom frequency is blank for three or more items).

Coding Tips and Special Populations

- Responses to PHQ-9© can indicate possible depression. Responses can be interpreted as follows:
    - Major Depressive Syndrome is suggested if—of the nine items—five or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
    - Minor Depressive Syndrome is suggested if, of the nine items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
    - In addition, PHQ-9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
        - 1-4: minimal depression
        - 5-9: mild depression
        - 10-14: moderate depression
        - 15-19: moderately severe depression
        - 20-27: severe depression

Note: The system must calculate the value in the field D0300 based on the following rules:

1. If all of the items in Column 2 have valid values (0,1,2,3), then D0300 should equal the simple sum of those values.
2. If any of the items in Column 2 are missing (That is, if they are blank because the corresponding item in Column 1 is equal to [9]), then count their values as zero in computing the sum.
3. If the number of missing items in Column 2(as defined above) is equal to one, then compute the

simple sum of the eight items in Column 2 that have valid values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in D0300.

4. If the number of missing items in Column 2(as defined above) is equal to two, then compute the simple sum of the 7 items in Column 2 that have valid values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in D0300.
5. If the number of missing items in Column 2(as defined above) is equal to three or more, then D0300 should equal [99]on the LTC Online Portal.

D0500: Caregiver Assessment of Individual Mood (PHQ-9-OV©)

(14-Day Look-Back)

D0500. Caregiver Assessment of Individual Mood (PHQ-9-OV*)			
Do not conduct if Individual Mood Interview (D0200-D0300) was completed			
Over the last 2 weeks, did the individual have any of the following problems or behaviors?			
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. Then move to column 2, Symptom Frequency, and indicate symptom frequency. **1. Symptom Presence** 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) **2. Symptom Frequency** 0. **Never or 1 day** 1. **2–6 days** (several days) 2. **7–11 days** (half or more of the days) 3. **12–14 days** (nearly every day)		**1. Symptom Presence**	**2. Symptom Frequency**
		↓ Enter Scores in Boxes ↓	
A.	Little interest or pleasure in doing things	☐	☐
B.	Feeling or appearing down, depressed, or hopeless	☐	☐
C.	Trouble falling or staying asleep, or sleeping too much	☐	☐
D.	Feeling tired or having little energy	☐	☐
E.	Poor appetite or overeating	☐	☐
F	Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H.	Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I.	States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J.	Being short-tempered, easily annoyed	☐	☐

Item Rationale

Health-related Quality of Life

- PHQ-9© **Individual Mood Interview** is preferred as it improves the detection of a possible mood disorder. However, a small percentage of individuals are unable or unwilling to complete the PHQ-9© **Individual Mood Interview**. Therefore, the nurse assessor should complete the PHQ-9-OV© **Caregiver Assessment of Mood** so that any behaviors, signs, or symptoms of mood distress are identified and treated.
- Persons unable to complete the PHQ-9© **Individual Mood Interview** may still have a mood disorder.
- Even if an individual was unable to complete the **Individual Mood Interview**, important insights may be gained from the responses that were obtained during the interview, as well as observations of the individual's behaviors and affect during the interview.
- The identification of these behaviors and observations are important in the detection of mood distress, as the signs and symptoms are very treatable.
- It is important to note that coding the presence of indicators in Section D does not automatically mean that the individual has a diagnosis of depression or other mood disorder. Assessors do not

make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators.

- Alternate means of assessing mood must be used for individuals who cannot communicate or refuse or are unable to participate in the PHQ-9© **Individual Mood Interview**. This ensures that information about their mood is not overlooked.

Planning for Care

- If the individual is not able to complete the PHQ-9© **Individual Mood Interview,** the nurse assessor should conduct a scripted interview with the caregiver, who may provide critical information for understanding mood and making decisions regarding the plan of care.

Steps for Assessment

Look-back period for this item is 14 days.

1. Conduct interview with the caregiver in a location that protects individual's privacy.
2. The same administration techniques outlined above for the PHQ-9© **Individual Mood Interview** and Interviewing Tips & Techniques should also be followed when caregivers are interviewed.
3. Encourage caregivers to report symptom frequency, even if he/she believes the symptom to be unrelated to depression.
4. Explore unclear responses, focusing the discussion on the specific symptom listed on the assessment rather than expanding into a lengthy clinical evaluation.
5. If frequency cannot be coded, talk to the caregiver and review medical records, if available, to inform the selection of a frequency code.

Examples of Caregiver Responses That Indicate Need for Follow-up

1. **D0500A, Little Interest or Pleasure in Doing Things**
   - He doesn't really do much.
   - He spends most of the time in his room.
2. **D0500B, Feeling or Appearing Down, Depressed, or Hopeless**
   - She cries frequently.
3. **D0500C, Trouble Falling or Staying Asleep, or Sleeping Too Much**
   - Her back hurts when she lies down.
   - He urinates a lot during the night.
4. **D0500D, Feeling Tired or Having Little Energy**
   - She is frequently tired.
   - He is having a bad spell with his COPD right now.
5. **D0500E, Poor Appetite or Overeating**
   - She has not wanted to eat much of anything lately.
   - He has a voracious appetite, more so than last week.
6. **D0500F, Indicating That S/he Feels Bad about Self, Is a Failure, or Has Let Self or Family Down**
   - She does get upset when there's something she can't do now because of her stroke.
   - He gets embarrassed when he can't remember something he thinks he should be able to.

7. **D0500G, Trouble Concentrating on Things, Such as Reading the Newspaper or Watching Television**
    - She says there's nothing good on TV.
    - She never watches TV.
    - He can't see to read a newspaper.
8. **D0500H, Moving or Speaking So Slowly That Other People Have Noticed. Or the Opposite— Being So Fidgety or Restless That S/he Has Been Moving Around a Lot More than Usual**
    - His arthritis slows him down.
    - He's bored and always looking for something to do.
9. **D0500I, States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self**
    - She says God should take her already.
    - He complains that man was not meant to live like this.
10. **D0500J, Being Short-Tempered, Easily Annoyed**
    - She's OK if you know how to approach her.
    - He can snap but usually when his pain is bad.

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency**.
- **Code 1, yes:** if symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency.**

Coding Instructions for Column 2. Symptom Frequency

- **Code 0, never or 1 day:** if caregiver indicates that the individual has never or has experienced the symptom on only 1 day.
- **Code 1, 2-6 days (several days):** if caregiver indicates that the individual has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if caregiver indicates that the individual has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if caregiver indicates that the individual has experienced the symptom for 12-14 days.=

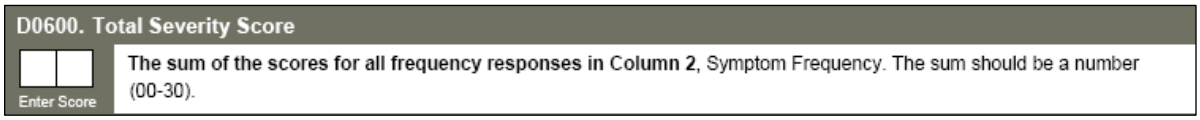
Coding Tips and Special Populations

- Ask the caregiver to select how often over the past two weeks the symptom occurred. Use the descriptive and/or numeric categories on the form (For example, "nearly every day" or 3 = 12-14 days) to select a frequency response.
- If you separated a longer item into its component parts, select the **highest** frequency rating that is reported.
- If the caregiver has difficulty selecting between two frequency responses, code for the **higher** frequency.
- Also, you may review medical records, if available, to select the frequency code.

Pediatric Tips

Complete section (D0500) if the child is less than seven years old or if the assessing nurse determines that the child is unable to answer section D0200.

D0600: Total Severity Score



Item Rationale

Health-related Quality of Life

- Review Item Rationale for D0300, **Total Severity Score**.
- The PHQ-9© Observational Version (PHQ-9-OV©) is adapted to allow the assessor to interview caregiver and identify a **Total Severity Score** for potential depressive symptoms.

Planning for Care

- The score can be communicated among health care providers and used to track symptoms and how they are changing over time.
- The score is useful for knowing when to request additional assessment by providers or mental health specialists for underlying depression.

Coding Instructions

The interview is successfully completed if the individual or caregiver were able to answer the frequency responses of at least 7 out of 10 items on the PHQ-9-OV©.

Coding Tips and Special Populations

Responses to PHQ-9-OV© can indicate possible depression. Responses can be interpreted as follows:

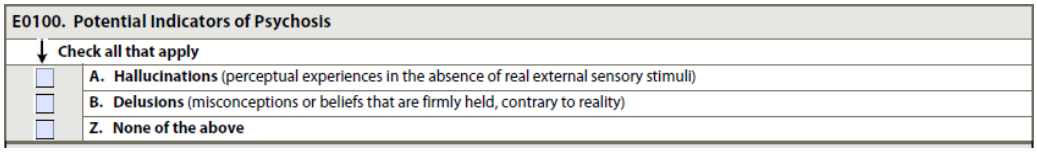
- Major Depressive Syndrome is suggested if—of the 10 items, five or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
- Minor Depressive Syndrome is suggested if—of the 10 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
- In addition, PHQ-9© Total Severity Score can be used to track changes in severity over time. Total Severity Score can be interpreted as follows:
    - 1-4: minimal depression
    - 5-9: mild depression
    - 10-14: moderate depression
    - 15-19: moderately severe depression
    - 20-30: severe depression

SECTION E: BEHAVIOR

Intent: The items in this section identify behavioral symptoms in the last 7days that may cause distress to the individual or may be distressing or disruptive to caregivers and family members. These behaviors may place the individual at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the individual. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the individual and on others are critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and plan of care interventions can be developed to improve the symptoms or reduce their impact.

This section focuses on the individual's actions, not the intent of his or her behavior. Because of their interactions with individuals, caregivers may have become used to the behavior and may underreport or minimize the individual's behavior by presuming intent (For example, "Mr. A. doesn't really mean to hurt anyone. He's just frightened"). Individual intent should not be taken into account when coding for items in this section.

E0100: Potential Indicators of Psychosis



E0100. Potential Indicators of Psychosis	
↓ Check all that apply	
☐	A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐	B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐	Z. None of the above

Definition

- **Hallucination -** The perception of the presence of something that is not actually there. It may be auditory or visual or involve smell, tastes or touch.
- **Delusion** - A fixed, false belief not shared by others that the individual holds even in the face of the contrary.

Item Rationale

Health-related Quality of Life

- Psychotic symptoms may be associated with
  - delirium,
  - dementia,
  - adverse drug effects,
  - psychiatric disorders, and
  - hearing or vision impairment
- Hallucinations and delusions can
  - Be distressing to individuals and their families,
  - Cause disability,
  - Interfere with delivery of medical, nursing, rehabilitative and personal care, and
  - Lead to dangerous behavior or possible harm.

Planning for Care

- Reversible and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of strategies should be to minimize the amount of disability and distress.

Steps for Assessment

1. Review the individual's medical record, if available, for the 7-day look-back period.
2. Interview the individual and caregivers regarding evidence of psychosis during the 7-day look-back period.
3. Observe the individual during conversations and the structured interviews in other assessment sections and listen for statements indicating an experience of hallucinations, or the expression of false beliefs (delusions).
4. Clarify potentially false beliefs:
    - When an individual expresses a belief that is plausible but alleged by others to be false (For example, history indicates that the individual's husband died 20 years ago, but the individual states her husband has been visiting her every day), try to verify the facts to determine whether there is reason to believe that it could have happened or whether it is likely that the belief is false.
    - When an individual expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. Do not, however, challenge the individual.
    - The individual's response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed.

Coding Instructions

Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply.

- **Check E0100A, hallucinations:** if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.
- **Check E0100B, delusions:** if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the individual holds true even in the face of evidence to the contrary.
- **Check E0100Z, none of the above:** if no hallucinations or delusions were present in the last 7 days.

Coding Tips and Special Populations

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

Pediatric Tips

- Most often the nurse assessor will ask the parent/caregiver if the child has had any of these symptoms in the look-back period.
- If you suspect that delusions or hallucinations are present you may ask the child "Do you hear people talk to you in your head?"

Examples

1. Mrs. Q carries on one side of a conversation, mentioning her daughter's name as if she is addressing her in person. When asked about this, she reports hearing her daughter's voice, even though the daughter is not present and no other voices can be heard in the environment.

   Coding: E0100A would be **checked.**
   Rationale: She reports an auditory sensation that occurs in the absence of any external stimulus. Therefore, this is a hallucination.

2. Mr. F reports that he heard a gunshot. In fact, there was a loud knock on the door. When this is explained to him, he accepts the alternative interpretation of the loud noise.

   Coding: E0100Z would be **checked.**
   Rationale: He misinterpreted a real sound in the external environment. Because he is able to accept the alternative explanation for the cause of the sound, his report of a gunshot is not a fixed false belief and is therefore not a delusion.

3. Mr. H announces that he must leave to go to work because he is needed in his office right away. He has been retired for 15 years. When reminded of this, he continues to insist that he must get to his office.

   Coding: E0100B would be **checked.**
   Rationale: He adheres to the belief that he still works, even after being reminded about his retirement status. Because the belief is held firmly despite an explanation of the real situation, it is a delusion.

E0200: Behavioral Symptom—Presence & Frequency

E0200. Behavioral Symptom - Presence & Frequency		
Note presence of symptoms and their frequency		
	↓ **Enter Codes in Boxes**	
Coding: 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**	☐	**A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	☐	**B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
	☐	**C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as 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)

Item Rationale

Health-related Quality of Life

- New onset of behavioral symptoms warrants prompt evaluation, assurance of individual safety, relief of distressing symptoms, and compassionate response to the individual.
- Reversible and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress.

Planning for Care

- Identification of the frequency and the impact of behavioral symptoms, on the individual and on others, are critical to distinguish behaviors that constitute problems—and may therefore require

treatment planning and intervention—from those that are not problematic.

- These behaviors may indicate unrecognized needs, preferences, or illness.
- Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and interventions can be developed to improve the symptoms or reduce their impact.
- Subsequent assessments and documentation can be compared to baseline to identify changes in the individual's behavior, including response to interventions.

Steps for Assessment

1. Review the medical record, if available, for the 7-day look-back period.
2. Interview caregivers and significant others regarding who had close interactions with the individual during the 7-day look-back period.

Coding Instructions

- **Code 0, behavior not exhibited:** if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7days.
- **Code1, behavior of this type occurred 1-3 days:** if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days.
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days.
- **Code 3, behavior of this type occurred daily:** if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days.

Coding Tips and Special Populations

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

Example

1. Every morning the caregiver tries to help Mr. T dress himself. On the last 4 out of 5 mornings he has hit or scratched the caregiver while attempting to dress him.

   Coding: E0200A would be coded 2, behavior of this type occurred 4-6 days, but less than daily.

E0300: Overall Presence of Behavioral Symptoms

E0300. Overall Presence of Behavioral Symptoms	
Enter Code ☐	**Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?** 0. **No** → Skip to E0800, Rejection of Care 1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

Item Rationale

- To determine whether or not additional items E0500, **Impact on the Individual**, and E0600, **Impact on Others,** are required to be completed.

Steps for Assessment

1. Review coding for item E0200 and follow these coding instructions:

Coding Instructions

- **Code 0, no:** if E0200A, E0200B, and E0200C all are coded 0, not present. Skip to **Rejection of Care—Presence & Frequency** item (E0800).
- **Code 1, yes:** if any of E0200A, E0200B, or E0200C were coded 1, 2, or 3. Proceed to complete **Impact on the Individual** item (E0500), and **Impact on Others** item (E0600).

E0500: Impact on Individual

E0500. Impact on Individual	
Enter Code ☐	Did any of the identified symptom(s): A. Put the individual at significant risk for physical illness or injury? 0. No 1. Yes
Enter Code ☐	B. Significantly interfere with the individual's care? 0. No 1. Yes
Enter Code ☐	C. Significantly interfere with the individual's participation in activities or social interactions? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Behaviors identified in item E0200 impact the individual's risk for significant injury, interfere with care or their participation in activities or social interactions.

Planning for Care

- Identification of the impact of the behaviors noted in E0200 may require treatment planning and intervention.
- Subsequent assessments and documentation can be compared to a baseline to identify changes in the individual's behavior, including response to interventions.

Steps for Assessment

1. Consider the previous review of the medical record, and caregiver interviews
2. Code E0500A, E0500B, and E0500C based on **all** of the behavioral symptoms coded in E0200.
3. Determine whether those behaviors put the individual at significant risk of physical illness or injury, whether the behaviors significantly interfered with the individual's care, and/or whether the behaviors significantly interfered with the individual's participation in activities or social interactions.

Coding Instructions for E0500A. Did Any of the Identified Symptom(s) Put the Individual at Significant Risk for Physical Illness or Injury?

- **Code 0, no:** if none of the identified behavioral symptom(s) placed the individual at clinically significant risk for a physical illness or injury.
- **Code 1, yes:** if any of the identified behavioral symptom(s) placed the individual at clinically significant risk for a physical illness or injury, even if no injury occurred.

Coding Instructions for E0500B. Did Any of the Identified Symptom(s) Significantly Interfere with the Individual's Care?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly interfered with the individual's care.
- **Code 1, yes:** if any of the identified behavioral symptom(s) impeded the delivery of essential medical, nursing, rehabilitative or personal care, including but not limited to assistance with activities of daily living, such as bathing, dressing, feeding, or toileting.

Coding Instructions for E0500C. Did Any of the Identified Symptom(s) Significantly Interfere with the Individual's Participation in Activities or Social Interactions?

- **Code 0, no:** if none of the identified symptom(s) significantly interfered with the individual's participation in activities or social interactions.
- **Code 1, yes:** if any of the identified behavioral symptom(s) significantly interfered with or decreased the individual's participation or caused individuals not to be included in activities or social interactions.

Coding Tips and Special Populations

- The term "significant" refers to effects, results, or consequences that materially affect or are likely to affect an individual's physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.
- For E0500A, code based on whether the risk for physical injury or illness is known to occur commonly under similar circumstances (That is, with individuals who exhibit similar behavior in a similar environment). Physical injury is trauma that results in pain or other distressing physical symptoms, impaired organ function, physical disability, or other adverse consequences, regardless of the need for medical, surgical, nursing, or rehabilitative intervention.
- For E0500B, code if the impact of the individual's behavior is impeding the delivery of care to such an extent that necessary or essential care (medical, nursing, rehabilitative or personal that is required to achieve the individual's goals for health and well-being) cannot be received safely, completely, or in a timely way without more than a minimal accommodation, such as simple change in care routines or environment.
- For E0500C, code if the impact of the individual's behavior is limiting or keeping the individual from engaging in solitary activities or hobbies, joining groups, or attending programmed activities or having positive social encounters with others.

Examples

1. Ms. P. frequently grabs and scratches her caregiver when they attempt to change her soiled brief, digging her nails into their skin. This makes it difficult to complete the care task.

Coding: E0500B would be **coded 1, yes**
Rationale: This behavior interfered with delivery of essential personal care.

2. Ms. B. cries out continuously, including when medication for her severe hypertension is offered. Crying out with pills in her mouth puts her at significant risk for aspiration, and her inability to take her medication also places her at risk for life-threatening complications of untreated hypertension.

   Coding: E0500A and E0500B would both be **coded 1, yes.**
   Rationale: The behavior interfered significantly with delivery of her care and put her at clinically significant risk for physical illness.

3. Mr. J. with severe dementia has continuous outbursts while awake despite all efforts made by the caregiver to address the issue, including trying to involve him in activities of choice.

   Coding: E0500C would be **coded 1, yes.**
   Rationale: The behavior interfered with his ability to participate in any activities.

E0600: Impact on Others

E0600. Impact on Others	
Enter Code ☐	Did any of the identified symptom(s): A. Put others at significant risk for physical injury? 0. No 1. Yes
Enter Code ☐	B. Significantly intrude on the privacy or activity of others? 0. No 1. Yes
Enter Code ☐	C. Significantly disrupt care or living environment? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Behaviors identified in item E0200 put others at risk for significant injury, intrude on their privacy or activities and/or disrupt their care or living environments. The impact on others is coded here in item E0600.

Planning for Care

- Identification of the behaviors noted in E0200 that have an impact on others may require treatment planning and intervention.
- Subsequent assessments and documentation can be compared with a baseline to identify changes in the individual's behavior, including response to interventions.

Steps for Assessment

1. Consider the previous review of the medical record, if available, and caregiver interviews.
2. To code E0600, determine if the behaviors identified put others at significant risk of physical illness or injury, intruded on their privacy or activities, and/or interfered with their care or living environments.

Coding Instructions for E0600A. Did Any of the Identified Symptom(s) Put Others at Significant Risk for Physical Injury?

- **Code 0, no:** if none of the identified behavioral symptom(s) placed caregivers or others at significant risk for physical injury.
- **Code 1, yes:** if any of the identified behavioral symptom(s) placed caregivers or others at significant risk for physical injury.

Coding Instructions for E0600B. Did Any of the Identified Symptom(s) Significantly Intrude on the Privacy or Activity of Others?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly intruded on the privacy or activity of others.
- **Code 1, yes:** if any of the identified behavioral symptom(s) kept others from enjoying privacy or engaging in informal activities.

Coding Instructions for E0600C. Did Any of the Identified Symptom(s) Significantly Disrupt Care or the Living Environment?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly disrupted delivery of care or the living environment.
- **Code 1, yes:** if any of the identified behavioral symptom(s) significantly disrupted delivery of care, or created a climate of excessive noise or interfered with organized activities.

Coding Tips and Special Populations

- The term "significant" refers to effects, results, or consequences that materially affect or are likely to affect an individual's physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.
- For E0600A, code based on whether the behavior placed others at significant risk for physical injury. Physical injury is trauma that results in pain or other distressing physical symptoms, impaired organ function, physical disability or other adverse consequences, regardless of the need for medical, surgical, nursing, or rehabilitative intervention.
- For E0600B, code based on whether the behavior violates the privacy of others or interrupts other individual's performance of activities of daily living or limits engagement in or enjoyment of informal social or recreational activities to such an extent that it causes caregivers or family members to experience distress (For example, displeasure or annoyance) or inconvenience, whether or not the caregivers or family members complain.
- For E0600C, code based on whether the behavior interferes with caregiver ability to deliver care or conduct organized activities, interrupts receipt of care or participation in organized activities by others and/or causes them to experience distress or adverse consequences.

Example

1. Mr. Q enters his daughter's room and rummages through her purse, frustrating her.

   Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes.**
   Rationale: This is an intrusion and violates the daughter's privacy.

E0800: Rejection of Care—Presence & Frequency

E0800. Rejection of Care – Presence & Frequency	
Enter Code ☐	**Did the individual reject evaluation or care** (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the individual's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the individual or family), and/or determined to be consistent with individual values, preferences, or goals. 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**

Item Rationale

Health-related Quality of Life

- Goals for health and well-being reflect the individual's wishes and objectives for health, function, and life satisfaction that define an acceptable quality of life for that individual.
- The individual's care preferences reflect desires, wishes, inclinations, or choices for care. Preferences do not have to appear logical or rational. Similarly, preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with "good judgment."
- An individual might reject/decline care because the care conflicts with his or her preferences and goals. In such cases, care rejection behavior is not considered a problem that warrants treatment to modify or eliminate the behavior.
- Care rejection may be manifested by verbally declining, statements of refusal, or through physical behaviors that convey aversion to, result in avoidance of, or interfere with the receipt of care.
- This type of behavior interrupts or interferes with the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.
- An individual's rejection of care might be caused by an underlying neuropsychiatric, medical, or dental problem. This can interfere with needed care that is consistent with the individual's preferences or established care goals. In such cases, care rejection behavior may be a problem that requires assessment and intervention.
- It is really a matter of choice. When rejection/decline of care is first identified it should be investigated and determined whether the rejection/decline of care is a matter of the individual's choice. Education should be provided and the individual's choices become part of the plan of care. On future assessments, this behavior would not be coded in this item.

Planning for Care

- Evaluation of rejection of care assists the provider in honoring the individual's care preferences tomeet his or her desired health care goals.
- Follow-up assessment should consider:
  - Whether established care goals clearly reflect the individual's preferences and goals, and
  - Whether alternative approaches could be used to achieve the individual's care goals.
- Determine whether a previous discussion identified an objection to the type of care or the way in which the care was provided. If so, determine approaches to accommodate the individual's preferences.

Steps for Assessment

1. Review the medical record, if available, and consult caregivers to determine whether the rejected

care is needed to achieve the individual's preferences and goals for health and well- being.

2. Review the medical record, if available, to find out whether the care rejection behavior was previously addressed and documented in discussions or in care planning with the individual, family, or significant others and determined to be an informed choice consistent with the individual's values, preferences, or goals; or whether that the behavior represents an objection to the way care is provided, but acceptable alternative care and/or approaches to care have been identified and employed.
3. If the individual exhibits behavior that appears to communicate a rejection of care (and that rejection behavior has not been previously determined to be consistent with the individual's values or goals), ask him or her directly whether the behavior is meant to decline or refuse care.
    - If the individual indicates that the intention is to decline or refuse, then ask him/ her about the reasons for rejecting care and about his/her goals for health care and well- being.
    - If the individual is unable or unwilling to respond to questions about his or her rejection of care or goals for health care and well-being, then interview the caregiver or family members to ascertain the individual's health care preferences and goals.

Coding Instructions

- **Code 0, behavior not exhibited:** if rejection of care consistent with goals was not exhibited in the last 7 days. If no rejection of care consistent with goals has been exhibited, skip to **Wandering—Impact** item (E1000).
- **Code 1, behavior of this type occurred 1-3 days:** if the individual rejected care consistent with goals 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the individual rejected care consistent with goals 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.
- **Code 3, behavior of this type occurred daily:** if the individual rejected care consistent with goals daily in the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.

Coding Tips and Special Populations

- The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the individual's preferences or goals for health and well-being or a choice made on behalf of the individual by a caregiver or family member or other proxy decision maker.
- Do not include behaviors that have already been addressed (For example, by discussion or care planning with the individual or caregiver) and determined to be consistent with the individual's values, preferences, or goals. Individuals, who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."

Examples

1. Mr. W goes to bed at night without changing out of the clothes he wore during the day. When the caregiver offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened two of the past five days. He was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.

Coding: E0800 would be coded 1, behavior of this type occurred 1-3 days.
Rationale: His care rejection behavior is not consistent with his values and goals for health and well-being. Therefore, this is classified as care rejection that occurred twice.

2. Ms. G is given her antibiotic medication prescribed for treatment of pneumonia and immediately spits the pills out on the floor. Her assessment indicates that she does not have any swallowing problems. This happened on each of the last four days. Her advance directive indicates that she would choose to take antibiotics to treat a potentially life-threatening infection.

   Coding: E0800 would be coded 2, behavior of this type occurred 4-6 days, but less than daily.
   Rationale: The behavioral rejection of antibiotics prevents her from achieving her stated goals for health care listed in her advance directives. Therefore, the behavior is coded as care rejection.

3. Ms. L who previously ate well and prided herself on following a healthy diet has been refusing to eat every day for the past two weeks. She complains that the food is boring and that she feels full after just a few bites. She says she wants to eat to maintain her weight and avoid getting sick, but cannot push herself to eat anymore.

   Coding: E0800 would be coded 3, behavior of this type occurred daily.
   Rationale: Her choice not to eat is not consistent with her goal of weight maintenance and health. Choosing not to eat may be related to a medical condition such as a disturbance of taste sensation, gastrointestinal illness, endocrine condition, depressive disorder, or medication side effects.

E0900: Wandering—Presence & Frequency

E0900. Wandering – Presence & Frequency	
Enter Code ☐	**Has the individual wandered?** 0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**

Item Rationale

Health-related Quality of Life

- Wandering may be a pursuit of exercise or a pleasurable leisure activity, or it may be related to tension, anxiety, agitation, or searching

Planning for Care

- It is important to assess the reason for wandering. Determine the frequency of its occurrence, and any factors that trigger the behavior or that decrease the episodes.
- Assess for underlying tension, anxiety, psychosis, drug-induced psychomotor restlessness, agitation, or unmet need (For example, for food, fluids, toileting, exercise, pain relief, sensory or cognitive stimulation, sense of security, companionship) that may be contributing to wandering.

Steps for Assessment

1. Review the medical record, if available, and interview the caregiver to determine whether wandering occurred during the 7-day look-back period.

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

2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period.

Coding Instructions for E0900

- **Code 0, behavior not exhibited:** if wandering was not exhibited during the 7-day look-back period. Skip to **Change in Behavior or Other Symptoms** item (E1100).
- **Code 1, behavior of this type occurred 1-3 days:** if the individual wandered on 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the individual wandered on 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).
- **Code 3, behavior of this type occurred daily:** if the individual wandered daily during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).

Coding Tips and Special Populations

- Pacing (repetitive walking with a driven/pressured quality) within a constrained space is not included in wandering.
- Traveling via a planned course to another specific place is not considered wandering.

E1000: Wandering—Impact

Answer this item only if E0900, Wandering—Presence & Frequency, was coded 1 (behavior of this type occurred 1-3 days), 2 (behavior of this type occurred 4-6 days, but less than daily), or 3 (behavior of this type occurred daily).

E1000. Wandering – Impact	
Enter ☐ Code	A. Does the wandering place the individual at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the residence/facility)? 0. No 1. Yes
Enter ☐ Code	B. Does the wandering significantly intrude on the privacy or activities of others? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Not all wandering is harmful.
- Some individuals who wander are at potentially higher risk for entering an unsafe situation.
- Some individuals who wander can cause significant disruption to others.

Planning for Care

- The plan of care should consider the impact of wandering on individual safety and disruption to others.
- The plan of care should be focused on minimizing these issues.
- Determine the need for environmental modifications (door alarms, door barriers, etc.) that enhance individual safety if wandering places the individual at risk.
- Determine when wandering requires interventions to reduce unwanted intrusions on other individuals or disruption of the living environment.

Steps for Assessment

1. Consider the previous review of the individual's wandering behaviors identified in E0900 for the 7 day look-back period.
2. Determine whether those behaviors put the individual at significant risk of getting into potentially dangerous places and/or whether wandering significantly intrudes on the privacy or activities of others based on clinical judgment for the individual.

Coding Instructions for E1000A. Does the Wandering Place the Individual at Significant Risk of Getting to a Potentially Dangerous Place?

- **Code 0, no:** if wandering does not place the individual at significant risk.
- **Code 1, yes:** if the wandering places the individual at significant risk of getting to a dangerous place (For example, wandering outside the home where there is heavy traffic)

Coding Instructions for E1000B. Does the Wandering Significantly Intrude on the Privacy or Activities of Others?

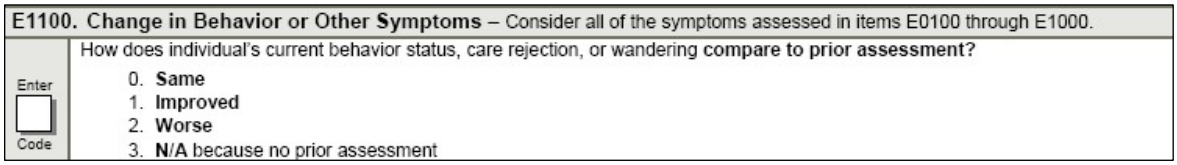
- **Code 0, no:** if the wandering does not intrude on the privacy or activity of others.
- **Code 1, yes:** if the wandering intrudes on the privacy or activities of others (That is, if the wandering violates other's privacy or interrupts their performance of activities of daily living or limits engagement in or enjoyment of social or recreational activities), whether or not they complain.

Example

1. Mr. J wanders away from his home in his pajamas at 3 a.m. When the caregiver finds him, he insists he is looking for his wife. This behavior had occurred before.

   Coding: E1000A would be **coded 1, yes.**
   Rationale: Wandering that resulted in elopement from his home placed him at significant risk.

E1100: Change in Behavior or Other Symptoms



E1100. Change in Behavior or Other Symptoms – Consider all of the symptoms assessed in items E0100 through E1000.

How does individual's current behavior status, care rejection, or wandering **compare to prior assessment?**

Enter Code

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior assessment

Item Rationale

Health-related Quality of Life

- Change in behavior may be an important indicator of
  - A change in health status or a change in environmental stimuli,
  - Positive response to treatment, and
  - Adverse effects of treatment

Planning for Care

- If behavior is worsening, assessment should consider whether it is related to
  - New health problems, psychosis, or delirium;
  - Worsening of pre-existing health problems;
  - A change in environmental stimuli or caregivers that influences behavior; and
  - Adverse effects of treatment.
- If behaviors are improved, assessment should consider what interventions should be continued or modified (For example, to minimize risk of relapse or adverse effects of treatment).

Steps for Assessment

1. Review responses provided to items E0100-E1000.
2. Compare with responses provided on prior assessment, if available.
3. Rate the overall behavior as same, improved, worse, or N/A because no prior assessment.

Coding Instructions

- **Code 0, same:** if overall behavior is the same (unchanged).
- **Code 1, improved:** if overall behavior is improved.
- **Code 2, worse:** if overall behavior is worse.
- **Code 3, N/A because no prior assessment.**

Coding Tips

- For individuals with multiple behavior symptoms, it is possible that different behaviors will vary in different directions over time. That is, one behavior may improve while another worsens or remains the same. Using clinical judgment, this item should be rated to reflect the **overall** direction of behavior change, estimating the net effects of multiple behaviors.

Example

1. At the time of the last assessment, Mr. D was ambulatory and would threaten and hit family members on a daily basis. He recently suffered a hip fracture and is not ambulatory. He is not approaching, threatening, or assaulting family members however, he is now combative when his caregiver tries to assist with dressing and bathing, and is hitting his caregiver on a daily basis.
   Coding: E1100 would be **coded 0, same.**
   Rationale: Although he is no longer assaulting family the danger to others and the frequency of these behaviors is the same as before, the overall behavior is rated as unchanged.

SECTION GG: FUNCTIONAL ABILITIES

Intent: This section includes items about functional abilities. It includes items focused on prior function, admission and discharge performance, performance throughout an individual's stay, mobility device use, and range of motion. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:

3. **Independent** - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

Enter Codes in Boxes

☐	A. **Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	B. **Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	C. **Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	D. **Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Item Rationale

- Knowledge of the individual's functioning prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the individual or their family about, or review the individual's medical records describing, the individual's prior functioning with everyday activities.

Coding Instructions

- **Code 3, Independent**: if the individual completed the activities by themself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help**: if the individual needed partial assistance from another person to complete the activities.
- **Code 1, Dependent**: if the helper completed the activities for the individual, or the assistance of two or more helpers was required for the individual to complete the activities.
- **Code 8, Unknown**: if the individual's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable**: if the activities were not applicable to the individual prior to the current illness, exacerbation, or injury.

Coding Tips

- Record the individual's usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.
- If no information about the individual's ability is available after attempts to interview the individual or their family and after reviewing the individual's medical record, code as 8, Unknown.
- Completing the stair activity for GG0100C indicates that an individual went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker, or stair lift) and/or with or without some level of assistance.
- Going up and down a ramp is not considered going up and down stairs for coding GG0100C.

Examples for Coding Prior Functioning: Everyday Activities

1. **Self-Care:** Individual T was admitted to an acute care facility after sustaining a stroke and subsequently admitted to the SNF for rehabilitation. Prior to the stroke, Individual T was independent in eating and using the toilet; however, Individual T required assistance for bathing and putting on and taking off their shoes and socks. The assistance needed was due to severe arthritic lumbar pain upon bending, which limited their ability to access their feet.

   Coding: GG0100A would be coded 2, Needed Some Help.
   Rationale: Individual T needed partial assistance from a helper to complete the activities of bathing and dressing. While Individual T did not need help for all self-care activities, they did need some help. Code 2 is used to indicate that Individual T needed some help for self-care.

2. **Self-Care:** Individual R was diagnosed with a progressive neurologic condition five years ago. They live in a long-term nursing facility and were recently hospitalized for surgery and have now been admitted to the SNF for skilled services. According to Individual R's spouse, prior to the surgery, Individual R required complete assistance with self-care activities, including eating, bathing, dressing, and using the toilet.

   Coding: GG0100A would be coded 1, Dependent.
   Rationale: Individual R's spouse has reported that Individual R was completely dependent in self-care activities that included eating, bathing, dressing, and using the toilet. Code 1, Dependent, is appropriate based upon this information.

3. **Indoor Mobility (Ambulation):** Approximately three months ago, Individual K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. Individual K has been living at home with their spouse and developed aspiration pneumonia. After this most recent hospitalization, they were admitted to the SNF for a diagnosis of aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Individual K needed some assistance when walking.

   Coding: GG0100B would be coded 2, Needed Some Help.
   Rationale: While the individual experienced a cardiac event three months ago, they recently had an exacerbation of a prior condition that required care in an acute care hospital and skilled nursing facility. The individual's prior functioning is based on the time immediately before their most recent condition exacerbation that required acute care.

4. **Indoor Mobility (Ambulation):** Individual L had a stroke one year ago that resulted in their using a wheelchair to self-mobilize, as they were unable to walk. Individual L subsequently had a second stroke and was transferred from an acute care unit to the SNF for skilled services.

   Coding: GG0100B would be coded 9, Not Applicable.
   Rationale: The individual did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke).

5. **Stairs:** Prior to admission to the hospital for bilateral knee surgery, followed by their recent admission to the SNF for rehabilitation, Individual V experienced severe knee pain upon ascending and particularly descending their internal and external stairs at home. Individual V required assistance from their spouse when using the stairs to steady them in the event their left knee would buckle. Individual V's spouse was interviewed about their spouse's functioning prior to admission, and the therapist noted Individual V's prior functional level information in their medical record.

   Coding: GG0100C would be coded 2, Needed Some Help.
   Rationale: Prior to admission, Individual V required some help in order to manage internal and external stairs.

6. **Stairs:** Individual P has expressive aphasia and difficulty communicating. SNF staff have not received any response to their phone messages to Individual P's family members requesting a return call. Individual P has not received any visitors since admission. The medical record from their prior facility does not indicate Individual P's prior functioning. There is no information to code item GG0100C, but there have been attempts at seeking this information.

   Coding: GG0100C would be coded 8, Unknown.
   Rationale: Attempts were made to seek information regarding Individual P's prior functioning; however, no information was available.

7. **Functional Cognition:** Individual K has mild dementia and recently sustained a fall resulting in complex multiple fractures requiring multiple surgeries. Individual K has been admitted to the SNF for rehabilitation. Individual K's caregiver reports that when living at home, Individual K needed reminders to take their medications on time, manage their money, and plan tasks, especially when they were fatigued.

   Coding: GG0100D would be coded 2, Needed Some Help.
   Rationale: Individual K required some help to recall, perform, and plan regular daily activities as a result of cognitive impairment.

8. **Functional Cognition:** Individual R had a stroke, resulting in a severe communication disorder. Their family members have not returned phone calls requesting information about Individual R's prior functional status, and their medical records do not include information about their functional cognition prior to the stroke.

   Coding: GG0100D would be coded 8, Unknown.
   Rationale: Attempts to seek information regarding Individual R's prior functioning were made; however, no information was available.

GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Check all that apply

☐	A.	Manual wheelchair
☐	B.	Motorized wheelchair and/or scooter
☐	C.	Mechanical lift
☐	D.	Walker
☐	E.	Orthotics/Prosthetics
☐	Z.	None of the above

Item Rationale

- Knowledge of the individual's routine use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the individual or their family or review the individual's medical records to determine the individual's use of prior devices and aids.

Coding Instructions

- Check all devices that apply.
- Check Z, None of the above: if the individual did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Coding Tips

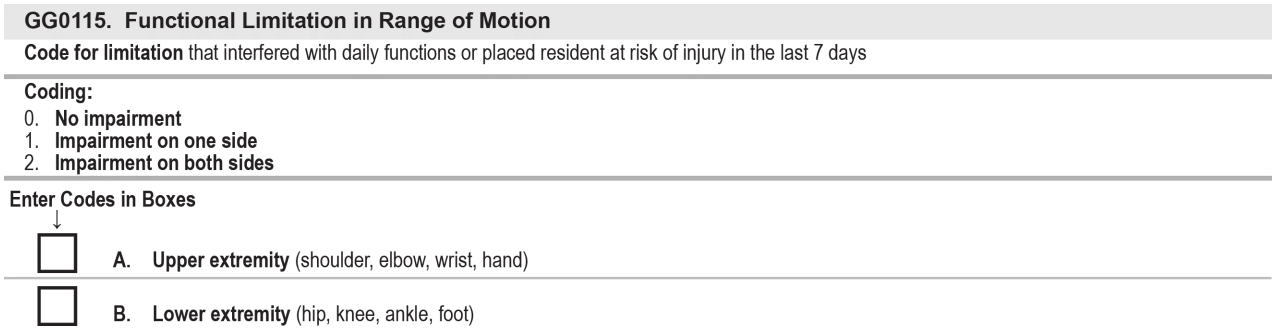
- For GG0110D, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).
- GG0110C, Mechanical lift, includes sit-to-stand, stand assist, stair lift, and full-body- style lifts.

Example for Coding Prior Device Use

1. Individual M is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. They are unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. They use a motorized wheelchair to mobilize.

   Coding: GG0110B would be checked.
   Rationale: Individual M used a motorized wheelchair prior to the current illness/injury.

GG0115: Functional Limitation in Range of Motion



GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

Coding:

0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

Enter Codes in Boxes

↓

☐ A. **Upper extremity** (shoulder, elbow, wrist, hand)

☐ B. **Lower extremity** (hip, knee, ankle, foot)

Intent: The intent of GG0115 is to determine whether functional limitation in range of motion (ROM) interferes with the individual's activities of daily living or places them at risk of injury. When completing this item, staff members should refer to items in GG0130 and GG0170 and view the limitation in ROM, taking into account activities the individual is able to perform.

Definitions

- **Functional Limitation in Range of Motion**: Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the individual at risk of injury.

Item Rationale

Health-related Quality of Life

- Functional impairment could place the individual at risk of injury or interfere with performance of activities of daily living.

Planning for Care

- Individualized care plans should address possible reversible causes such as deconditioning and adverse side effects of medications or other treatments.

Steps for Assessment

1. Review the medical record for references to functional range-of-motion limitation during the 7-day observation period.
2. Talk with staff members who work with the individual as well as family/significant others about any impairment in functional ROM.
3. Coding for functional ROM limitations is a three-step process:
   - Test the individual's upper and lower extremity ROM (See item 6 below for examples).
   - If the individual is noted to have limitation of upper- and/or lower-extremity ROM, review GG0130 and GG0170 and/or directly observe the individual to determine whether the limitation interferes with function or places the individual at risk for injury.
   - Code GG0115A and GG0115B as appropriate based on the above assessment.
4. Assess the individual's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (For example, recent fracture, joint replacement or pain).
5. Staff member observations of various activities, including ADLs, may be used to determine whether any ROM limitations have an impact on the individual's functional abilities.
6. Although this item codes for the presence or absence of functional limitation related to ROM, thorough

assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:

- Ask the individual to follow your verbal instructions for each movement.
- Demonstrate each movement (For example, ask the individual to do what you are doing).
- Actively assist the individual with the movements by supporting their extremity and guiding it through the joint ROM.

Lower Extremity—includes hip, knee, ankle, and foot
While individual is lying supine in a flat bed, instruct the individual to flex (pull toes up toward head) and extend (push toes down away from head) each foot. Then ask the individual to lift their leg one at a time, bending it at the knee to a right angle (90 degrees). Then ask the individual to slowly lower their leg and extend it flat on the mattress. If assessing lower-extremity ROM by observing the individual, the flexion and extension of the foot mimics the motion on the pedals of a bicycle. Extension might also be needed to don a shoe. If assessing bending at the knee, the motion would be similar to lifting of the leg when donning lower- body clothing.

Upper Extremity—includes shoulder, elbow, wrist, and fingers
For each hand, instruct the individual to make a fist and then open the hand. With individual seated in a chair, instruct them to reach with both hands and touch palms to back of head. Then ask individual to touch each shoulder with the opposite hand. Alternatively, observe the individual donning or removing a shirt over the head. If assessing upper-extremity ROM by observing the individual, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair.

Coding Tips

- Do not look at limited ROM in isolation. You must determine whether the limited ROM has an impact on functional ability or places the individual at risk for injury. For example, if the individual has an amputation, it does not automatically mean that they are limited in function. An individual with an amputation may not have a particular joint in which a certain range of motion can be tested; however, that does not mean that the individual necessarily has a limitation in completing activities of daily living, nor does it mean that the individual is automatically at risk of injury. There are many amputees who function extremely well and can complete all activities of daily living either with or without the use of prosthetics. If an individual with an amputation does indeed have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.

Coding Instructions for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); GG0115B, Lower Extremity (Hip, Knee, Ankle, Foot)

- **Code 0, no impairment**: if individual has full functional range of motion on the right and left side of upper/lower extremities.
- **Code 1, impairment on one side**: if individual has an upper- and/or lower-extremity impairment on one side that interferes with daily functioning or places the individual at risk of injury.
- **Code 2, impairment on both sides**: if an individual has an upper- and/or lower-extremity impairment on both sides that interferes with daily functioning or places the individual at risk of injury.

Examples for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); GG0115B, Lower Extremity (Hip, Knee, Ankle, Foot)

1. The individual can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. Theyare able to perform grooming activities (For example, brush their teeth, comb their hair) with their right upper extremity and are also able to pivot to their wheelchair with the assistance of one person. Theyaretheir left side (limited arm, hand, and leg motion), as they have a flaccid left hemiparesis from a prior stroke.

   Coding: GG0115A would be coded 1, upper-extremity impairment on one side. GG0115B would be coded 1, lower-extremity impairment on one side.
   Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this individual has limited ROM that impairs function on the left side, as indicated above, the individual can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the individual with assistive devices or physical assistance that allows the individual to be as independent as possible.

2. The individual had shoulder surgery and can't brush their hair with their right arm or raise their right arm above their head. The individual can brush their hair with their left arm and has no impairment on the lower extremities.

   Coding: GG0115A would be coded 1, upper-extremity impairment on one side. GG0115B would be coded 0, no impairment.
   Rationale: Impairment due to shoulder surgery affects only one side of their upper extremities.

3. The individual has a diagnosis of Parkinson's and ambulates with a shuffling gait. The individual has had three falls in the past quarter and often forgets their walker, which they need to ambulate. They have tremors of both upper extremities that make it very difficult for them to feed themself, brush their teeth, or write.

   Coding: GG0115A would be coded 2, upper-extremity impairment on both sides. GG0115B would be coded 2, lower-extremity impairment on both sides.
   Rationale: Impairment due to Parkinson's disease affects the individual's upper and lower extremities on both sides.

GG0120: Mobility Devices

GG0120. Mobility Devices

Check all that were normally used in the last 7 days

☐	A.	**Cane/crutch**
☐	B.	**Walker**
☐	C.	**Wheelchair** (manual or electric)
☐	D.	**Limb prosthesis**
☐	Z.	**None of the above** were used

Item Rationale

Health-related Quality of Life

- Maintaining independence is important to an individual's feelings of autonomy and self- worth. The use of devices may assist the individual in maintaining that independence.

Planning for Care

- An individual's ability to move about their room, unit or nursing home may be directly related to the use of devices. It is critical that staff members assure that the individual's independence is optimized by making mobility devices available on a daily basis, if needed.

Steps for Assessment

1. Review the medical record for references to locomotion during the 7-day observation period.
2. Talk with staff members who work with the individual as well as family/significant others about devices the individual used for mobility during the observation period.
3. Observe the individual during locomotion.

Coding Instructions

Record the type(s) of mobility devices the individual normally uses for locomotion (in room and in facility). Check all that apply:

- **Check GG0120A, Cane/crutch**: if they used a cane or crutch (single-prong, tripod, quad cane)
- **Check GG0120B, Walker**: if they used a walker or hemi-walker, including an enclosed frame-wheeled walker with or without a posterior seat and lap cushion. Also check this item if the individual walks while pushing a wheelchair for support.
- **Check GG0120C, Wheelchair (manual or electric)**: if they normally sits in a wheelchair when moving about. Include wheelchairs that are hand propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.
- **Check GG0120D, Limb prosthesis**: if they used an artificial limb to replace a missing extremity.
- **Check GG0120Z, None of the above**: if they used none of the mobility devices listed in GG0120 or locomotion did not occur during the observation period.

Examples

1. The individual uses a quad cane daily to walk in the room and on the unit. The individual uses a standard push wheelchair that they self-propel when leaving the unit because of their issues with endurance.

   Coding: GG0120A, Cane/crutch**,** and GG0120C, Wheelchair, would be checked.
   Rationale: The individual uses a quad cane in their room/on the unit and a wheelchair off the unit.

2. The individual has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied, the individual is able to ambulate independently.

   Coding: GG0120D, Limb prosthesis**,** would be checked.
   Rationale: The individual uses a leg prosthesis for ambulating.

GG0130: Self-Care (3-day assessment period) Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	1. Admission Performance
	Enter Codes in Boxes ↓
A.	**Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
B.	**Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
C.	**Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
E.	**Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
F.	**Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
G.	**Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
H.	**Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
I.	**Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

GG0130: Self-Care (3-day assessment period) Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	3. Discharge Performance
Enter Codes in Boxes ↓	
☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

GG0130: Self-Care (OBRA/Interim)

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Definitions

- **ADL**: Tasks related to personal care, such as any of the tasks listed in GG0130 and GG0170.
- **Usual Performance**: An individual's functional status can be impacted by the environment or situations encountered at the facility. Observing the individual's interactions with others in different locations and circumstances is important for a comprehensive understanding of the individual's functional status. If the individual's functional status varies, record the individual's usual ability to perform each activity. Do not record the individual's best performance and do not record the individual's worst performance, but rather record the individual's usual performance.
- **Qualified Clinician**: Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
- **Prior to the Benefit of Services**: Before the provision of any care by facility staff that would result in more independent coding.

Item Rationale

Health-related Quality of Life

- Individuals may have self-care limitations on admission. In addition, individuals may be at risk of further functional decline during their stay in the facility.
- Most nursing home individuals need some physical assistance and are at risk of further physical decline. The amount of assistance needed and the risk of decline vary from individual to individual.
- A wide range of physical, neurological, and psychological conditions and cognitive factors can adversely affect physical function.
- Dependence on others for ADL assistance can lead to feelings of helplessness, isolation, diminished self-worth, and loss of control over one's destiny.
- As inactivity increases, complications such as pressure ulcers, falls, contractures, depression, and muscle wasting may occur.

Planning for Care

- Individualized care plans should address strengths and weaknesses, possible reversible causes such as deconditioning, and adverse side effects of medications or other treatments. These may contribute to loss of self-sufficiency. In addition, some neurologic injuries such as stroke may continue to improve for months after an acute event.
- For some individuals, cognitive deficits can limit ability or willingness to initiate or participate in self-care or restrict understanding of the tasks required to complete ADLs.
- Individualized care plans should be based on an accurate assessment of the individual'sindividual's self-performance and the amount and type of support being provided to the individual.
- Some individuals might require lower levels of assistance if they are provided with appropriate devices and aids, assisted with segmenting tasks, or given adequate time to complete a task while being provided with graduated prompting and assistance. This type of supervision requires skill, time, and patience.
- Some individuals in the community setting are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.
- Graduated prompting/task segmentation (helping the individual break tasks down into smaller components) and allowing the individual time to complete an activity can often increase functional independence.

Steps for Assessment

1. Assess the individual's self-care performance based on direct observation, incorporating individual self-reports and reports from qualified clinicians, care staff, or family documented in the individual's medical record during the assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the individual during the assessment period.
    - For individuals in a Medicare Part A stay, the admission assessment period is the first 3 days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. The admission assessment period for individuals who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600, Entry Date.
        - **Note:** If A0310B = 01 and A0310A = 01 – 06 indicating a 5-day PPS assessment combined with an OBRA assessment, the assessment period is the first 3 days of the stay beginning on A2400B. In these scenarios, do not complete Column 5. OBRA/Interim Performance.

- For individuals in a Medicare Part A stay, the assessment period for the Interim Payment Assessment (A0310B = 08) is the last 3 days (That is, the ARD plus 2 previous calendar days).
- For individuals in a Medicare Part A stay, the discharge assessment period is the End Date of Most Recent Medicare Stay (A2400C) plus 2 previous calendar days. For all other Discharge assessments, the assessment period is A2000, Discharge Date plus 2 previous calendar days.
- When completing an OBRA-required assessment other than an Admission assessment (That is, ,A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.

2. Individuals should be allowed to perform activities as independently as possible, as long as they are safe.
3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (For example, rehabilitation staff, nursing agency staff). Thus, "helper" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because an individual's performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. For individuals in a Medicare Part A stay, the admission functional assessment, when possible, should be conducted prior to the benefit of services to reflect the individual's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld to conduct the functional assessment.

6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Individual assessments are to be done in compliance with facility, Federal, and State requirements.

   Coding Instructions

   When coding the individual's usual performance, use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.

   - **Code 06, Independent**: if the individual completes the activity by themself with no assistance from a helper.
   - **Code 05, Setup or clean-up assistance**: if the helper sets up or cleans up; individual completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the individual requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).
   - **Code 04, Supervision or touching assistance**: if the helper provides verbal cues or touching/steadying/contact guard assistance as individual completes activity. Assistance may be provided throughout the activity or intermittently. For example, the individual requires verbal cueing, coaxing, or general supervision for safety to complete activity; or the individual may require only incidental help such as contact guard or steadying assist during the activity.
     - **Code 04, Supervision or touching assistance**: if the individual requires only verbal cueing to complete the activity safely.
   - **Code 03, Partial/moderate assistance**: if the helper does **LESS THAN HALF** the effort. Helper

lifts, holds, or supports trunk or limbs, but provides less than half the effort.

- **Code 02, Substantial/maximal assistance**: if the helper does **MORE THAN HALF** the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Code 01, Dependent**: if the helper does **ALL** of the effort. Individual does none of the effort to complete the activity; or the assistance of two or more helpers is required for the individual to complete the activity.
    - **Code 01, Dependent**: if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands-on assistance.
    - **Code 01, Dependent**: if an individual requires the assistance of two helpers to complete an activity (one to provide support to the individual and a second to manage the necessary equipment to allow the activity to be completed).
- **Code 07, Individual refused**: if the individual refused to complete the activity.
- **Code 09, Not applicable**: if the activity was not attempted and the individual did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations**: if the individual did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns**: if the activity was not attempted due to medical condition or safety concerns.

Decision Tree

Use this decision tree to code the patient's performance on the assessment instrument. If helper assistance is required because the individual's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the individual did not perform the activity and a helper did not perform that activity for the individual.

OBJ

Assessment Period

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the individual is admitted for a SNF Part A stay. Additionally, an OBRA Admission assessment (A0310A = 1) is required for a new individual and, under some circumstances, a returning individual and must be completed by the end of day 14. Please refer to Section 2.6 of this Manual for additional information about the OBRA Admission assessment.
    - For the 5-Day PPS assessment, code the individual's functional status based on a clinical assessment of the individual's performance that occurs soon after the individual's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the individual's admission baseline status and are to be based on an assessment. The scores should reflect the individual's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the individual benefitting from treatment interventions to determine the individual's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheldto conduct the functional assessment.
    - For an OBRA Admission assessment, code the individual's usual performance during first 3 days of their stay starting with the date in A1600, Entry Date.
- **OBRA/Interim:** The Interim Payment Assessment (IPA) (A0310B = 08) is an optional assessment that may be completed by providers to report a change in the individual's PDPM classification. OBRA assessments (A0310A = 01 – 06) are required for individuals in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual.
    - For Section GG on the IPA or an OBRA assessment, providers will use the same 6-point scale and activity not attempted codes to assess the individual's usual functional performance during the 3-day assessment period.
    - The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (That is, the ARD plus 2 previous calendar days). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.
    - For Section GG on OBRA assessments other than the Admission assessment (That is, A0310A = 02 – 06), the assessment period is the last 3 days (That is, the ARD plus 2 previous calendar days).
- **Discharge:** The Part A PPS Discharge assessment is required to be completed as a standalone assessment when the individual's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay) and the individual remains in the facility. The Part A PPS Discharge assessment must be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the individual's Discharge Date (A2000). An OBRA Discharge assessment is required when the individual is discharged from the facility. Please see Chapter 2 and Section A of the RAI Manual for additional details regarding Discharge assessments.
    - For the PPS Discharge assessment (That is, standalone Part A PPS or combined OBRA/Part A PPS), code the individual's discharge functional status, based on a clinical assessment of the individual's performance that occurs as close to the time of the individual's discharge from

Medicare Part A as possible. This functional assessment must be completed within the last 3 calendar days of the individual's Medicare Part A stay, which includes the day of discharge from Medicare Part A plus 2 previous calendar days prior to the day of discharge from Medicare Part A.

- On standalone OBRA Discharge assessments (That is, A0310F = 10 or 11 AND A0310H = 0), code the individual's usual performance during last 3 days of their stay (That is A2000, Discharge Date plus 2 previous calendar days).

Coding Tips

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the individual, be familiar with the definition for each activity (For example, eating, oral hygiene). For example, when assessing Eating (item GG0130C), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the individual.
- Individuals with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the individual's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).
- If the individual does not attempt the activity and a helper does not complete the activity for the individual during the entire assessment period, code the reason the activity was not attempted. For example, code as 07 if the individual refused to attempt the activity; code as 09 if the activity is not applicable for the individual (the activity did not occur at the time of the assessment and prior to the current illness, injury, or exacerbation); code as 10 if the individual was not able to attempt the activity due to environmental limitations; or code as 88 if the individual was not able to attempt the activity due to medical condition or safety concerns.
- An activity can be completed independently with or without devices. If the individual uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.
- If two or more helpers are required to assist the individual to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the individual's performance of an activity, ask probing questions to the care staff about the individual, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the individual's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.
- CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility activities. Clinical assessments may include any device or equipment that the individual can use to allow them to safely complete the activity as independently as possible.
- Do not code self-care and mobility activities with use of a device that is restricted to individual use during therapy sessions (For example, parallel bars, exoskeleton, or overhead track and harness systems).

Tips for Coding the Individual's Usual Performance

- When coding the individual's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the individual's best performance, and do not record the individual's worst performance, but rather record the individual's usual performance during the assessment period.
- Code based on the individual's performance. Do not record the staff's assessment of the individual's potential capability to perform the activity.
- If the individual performs the activity more than once during the assessment period and the individual's performance varies, coding in Section GG should be based on the individual's "usual performance," which is identified as the individual's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the individual's Self-Care performance varies during the assessment period, report the individual's usual performance, not the individual's most independent performance and not the individual's most dependent performance. A provider may need to use the entire assessment period to obtain the individual's usual performance.

Coding Tips for GG0130A, Eating

- The intent of GG0130A, Eating is to assess the individual's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the individual.
- The administration of tube feedings and parenteral nutrition is not considered when coding this activity.
- The following is guidance for some situations in which an individual receives tube feedings or parenteral nutrition:
    - If the individual does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a **new (recent- onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns.
    - If the individual does not eat or drink by mouth at the time of the assessment, and the individual did not eat or drink by mouth **prior to the current** illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the individual did not perform this activity prior to the current illness, exacerbation, or injury.
    - If the individual eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or parenteral nutrition, code Eating based on the amount of assistance the individual requires to eat and drink by mouth.
    - Assistance with tube feedings or parenteral nutrition is not considered when coding the item Eating.
- If an individual requires assistance (For example, supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing.
- If an individual swallows safely without assistance, exclude swallowing from consideration when coding GG0130A, Eating.

- If the individual eats finger foods using their hands, then code Eating based upon the amount of assistance provided. If the individual eats finger foods with their hands independently, for example, the individual would be coded as 06, Independent.
- For an individual taking only fluids by mouth, the item may be coded based on ability to bring liquid to the mouth and swallow liquid, once the drink is placed in front of the individual.

Examples for Coding Performance

Note: The following are coding examples for each Self-Care item. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the individual completing an activity across different times of the day and different days.

Examples for GG0130A, Eating

1. **Eating:** Individual S has multiple sclerosis, affecting their endurance and strength. Individual S prefers to feed themself as much as they are capable. During all meals, after eating three-fourths of the meal by themself, Individual S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed them the remainder of the meal.

   Coding: GG0130A would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort for the individual to complete the activity of eating for all meals.

2. **Eating:** Individual M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Individual M's hand that supports the eating utensil within their hand. At the start of each meal Individual M can bring food and liquids to their mouth. Individual M then tires and the certified nursing assistant feeds them more than half of each meal.

   Coding: GG0130A would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort for the individual to complete the activity of eating at each meal.

3. **Eating:** The dietary aide opens all of Individual S's cartons and containers on their food tray before leaving the room. There are no safety concerns regarding Individual S's ability to eat. Individual S eats the food themself, bringing the food to their mouth using appropriate utensils and swallowing the food safely.

   Coding: GG0130A would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provided setup assistance prior to the eating activity.

4. **Eating:** Individual H does not have any food consistency restrictions but often needs to swallow 2 or 3 times so that the food clears their throat due to difficulty with pharyngeal peristalsis. They requires verbal cues from the certified nursing assistant to use the compensatory strategy of extra swallows to clear the food.

   Coding: GG0130A would be coded 04, Supervision or touching assistance.
   Rationale: Individual H swallows all types of food consistencies and requires verbal cueing

(supervision) from the helper.

5. **Eating:** Individual R is unable to eat by mouth since they had a stroke one week ago. They receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

   Coding: GG0130A would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The individual does not eat or drink by mouth at this time due to their recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to their recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

Coding Tips for GG0130B, Oral hygiene

- If an individual does not perform oral hygiene during therapy, determine the individual's abilities based on performance of an ADL activity.
- For an individual who is edentulous, code Oral hygiene based on the type and amount of assistance required from a helper to clean the individual's gums.

Examples for GG0130B, Oral hygiene

1. **Oral hygiene:** Before bedtime, the nurse provides steadying assistance to Individual S as they walks to the bathroom. The nurse applies toothpaste onto Individual S's toothbrush. Individual S then brushes their teeth at the sink in the bathroom without physical assistance or supervision. Once Individual S is done brushing their teeth and washing their hands and face, the nurse returns and provides steadying assistance as the individual walks back to their bed.

   Coding: GG0130B would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before Individual S brushes their teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.*

2. **Oral hygiene:** At night, the certified nursing assistant provides Individual K water and toothpaste to clean their dentures. Individual K cleans their upper denture plate. Individual K then cleans half of their lower denture plate, but states they are tired and unable to finish cleaning their lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Individual K replaces the dentures in their mouth.

   Coding: GG0130B would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

3. **Oral hygiene:** Individual W is edentulous (without teeth) and their dentures no longer fit their gums. In the morning and evening, Individual W begins to brush their upper gums after the helper applies toothpaste onto their toothbrush. Individual W brushes their upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing the back upper gums and their lower gums.

Coding: GG0130B would be coded 02, Substantial/maximal assistance.
Rationale: The individual begins the activity. The helper completes the activity by performing more than half the effort.

4. **Oral hygiene:** Individual D has experienced a stroke. They can brush their teeth while sitting on the side of the bed, but when the certified nursing assistant hands them the toothbrush and toothpaste, they look up at them puzzled what to do next. The certified nursing assistant cues Individual D to put the toothpaste on the toothbrush and instructs them to brush their teeth. Individual D then completes the task of brushing their teeth.

   Coding: GG0130B would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the individual in completing the activity of brushing their teeth.

Coding Tips for GG0170B, Toileting hygiene

- Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. If the individual completes a bowel toileting program in bed, code the item Toileting hygiene based on the individual's need for assistance managing clothing and perineal cleansing.
- Includes:
  - Performing perineal hygiene.
  - Managing clothing (including undergarments and incontinence products, such as incontinence briefs or pads) before and after voiding or having a bowel movement.
  - Adjusting clothing relevant to the individual individual.
- If the individual has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the individual before and after moving their bowels.
- When the individual requires different levels of assistance to perform toileting hygiene after voiding versus after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity.
- If an individual manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.
- If an individual has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment.
  - For example, if the individual has an indwelling urinary catheter and has bowel movements, code Toileting hygiene based on the type and amount of assistance needed by the individual before and after moving their bowels. This may include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.

Examples for GG0130C, Toileting hygiene

1. **Toileting hygiene:** Individual J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Individual J pulls down their pants and underwear before sitting down on the commode. When Individual J is finished voiding or having a bowel movement, the

certified nursing assistant provides steadying assistance as Individual J wipes their perineal area and pulls up their pants and underwear without assistance.

Coding: GG0130C would be coded 04, Supervision or touching assistance.
Rationale: The helper provides steadying (touching) assistance to the individual to complete toileting hygiene.

2. **Toileting hygiene:** Individual J is morbidly obese and has a diagnosis of debility. They request the use of a bedpan when voiding or having bowel movements and require two certified nursing assistants to pull down their pants and underwear and mobilize them onto and off the bedpan. Individual J is unable to complete any of their perineal/perianal hygiene. Both certified nursing assistants help Individual J pull up their underwear and pants.

   Coding: GG0130C would be coded 01, Dependent.
   Rationale: The assistance of two helpers was needed to complete the activity of toileting hygiene.

3. **Toileting hygiene:** Individual C has Parkinson's disease and significant tremors that cause intermittent difficulty for them to perform perineal hygiene after having a bowel movement in the toilet. They walk to the bathroom with close supervision and lower their pants but ask the certified nursing assistant to help them with perineal hygiene after moving their bowels. They then pull up their pants without assistance.

   Coding: GG0130C would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort. The individual performs two of the three toileting hygiene tasks by themself. Walking to the bathroom is not considered when scoring toileting hygiene.

4. **Toileting hygiene:** Individual Q has a progressive neurological disease that affects their fine and gross motor coordination, balance, and activity tolerance. They wear a hospital gown and underwear during the day. Individual Q uses a bedside commode as they steady themself in standing with one hand and initiates pulling down their underwear with the other hand but need assistance to complete this activity due to their coordination impairment. After voiding, Individual Q wipes their perineal area without assistance while sitting on the commode. When Individual Q has a bowel movement, a certified nursing assistant performs perineal hygiene as Individual Q needs to steady themself with both hands to stand for this activity. Individual Q is usually too fatigued at this point and requires full assistance to pull up their underwear.

   Coding: GG0130C would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort needed for the individual to complete the activity of toileting hygiene.

Coding Tips for GG0130E, Shower/bathe self

- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the individual's back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.

- Assessment of Shower/bathe self can take place in any location including a shower or bath or at a sink or in bed (That is, full body sponge bath). Bathing can be assessed with the individual seated on a tub bench.
- Code 05, Setup or clean-up assistance, if the individual can complete bathing tasks only after a helper retrieves or sets up supplies necessary to perform the included tasks.
- Code 05, Setup or clean-up assistance, if the only help the individual requires is assistance before the bathing activity to cover wounds or devices for water protection during bathing.
- If the individual cannot bathe their entire body because of a medical condition (For example, a cast or a nonremovable dressing), then code Shower/bathe self based on the amount of assistance needed to complete the activity.

Examples for GG0130E, Shower/bathe self

1. **Shower/bathe self:** Individual J sits on a tub bench as they wash, rinse, and dry themself. A certified nursing assistant stays with them to ensure their safety, as Individual J has had instances of losing their sitting balance. The certified nursing assistant also provides lifting assistance as Individual J gets onto and off of the tub bench.

   Coding: GG0130E would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision as Individual J washes, rinses, and dries themself. The transfer onto or off of the tub bench is not considered when coding the Shower/bathe self activity.

2. **Shower/bathe self:** Individual E has a severe and progressive neurological condition that has affected their endurance as well as their fine and gross motor skills. They are transferred to the shower bench with partial/moderate assistance. Individual E showers while sitting on a shower bench and washes their arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of their body, as a result of Individual E's fatigue, to complete the activity. Individual E uses a hand-held showerhead to rinse themself but tires halfway through the task. The certified nursing assistant dries Individual E's entire body.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper assists Individual E with more than half of the task of showering, which includes bathing, rinsing, and drying their body. The transfer onto the shower bench is not considered in coding this activity.

3. **Shower/bathe self:** Individual Y has limited mobility resulting from their multiple and complex medical conditions. They prefer to wash their body while sitting in front of the sink in their bathroom. A helper assists with washing, rinsing, and drying Individual Y's arms/hands, upper legs, lower legs, buttocks, and back.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper completed more than half the activity. Bathing may occur at the sink. When coding this activity, do not include assistance provided with washing, rinsing, or drying the individual's back.

Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the individual dresses themself and a helper retrieves or puts away the individual's clothing, then code 05, Setup or clean-up assistance.
- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the individual is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the individual needs when coding the dressing item.
- The following items are considered a piece of clothing when coding the dressing items:
  - Upper body dressing examples: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
  - Lower body dressing examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.
  - Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.
- If an individual requires assistance with dressing, including assistance with buttons, fasteners and/or fastening a bra, code based on the type and amount of assistance required to complete the entire dressing activity.
- Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.
- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.
- For individuals with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
  - If the individual performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.
  - If the individual did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the individual had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable -Not attempted and the individual did not perform this activity prior to the current illness, exacerbation, or injury.
- For individuals with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
  - If the individual performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.

- If the individual performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Examples for GG0130F, Upper body dressing

1. **Upper body dressing:** Individual Y has right-side upper extremity weakness as a result of a stroke and has worked in therapy to relearn how to dress their upper body. During the day, they require a certified nursing assistant only to place their clothing next to their bedside. Individual Y can now use compensatory strategies to put on their bra and top without any assistance. At night they remove their top and bra independently and put the clothes on the nightstand, and the certified nursing assistant puts them away in their dresser**.**

   Coding: GG0130F would be coded 05, Setup or clean-up assistance.
   Rationale: Individual Y dresses and undresses their upper body and requires a helper only to retrieve and put away their clothing, that is, setting up the clothing for their use. The description refers to Individual Y as "independent" (when removing clothes), but they need setup assistance, so they are not independent with regard to the entire activity of upper body dressing.

2. **Upper body dressing:** Individual Z wears a bra and a sweatshirt most days while in the SNF. They require assistance from a certified nursing assistant to initiate the threading of their arms into their bra. Individual Z completes the placement of the bra over their chest. The helper hooks the bra clasps. Individual Z pulls the sweatshirt over their arms, head, and trunk. When undressing, Individual Z removes the sweatshirt, with the helper assisting them with one sleeve. Individual Z slides the bra off, once it has been unclasped by the helper.

   Coding: GG0130F would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides assistance with threading Individual Z's arms into their bra and hooking and unhooking their bra clasps and assistance with removing one sleeve of the sweatshirt. Individual Z performs more than half of the effort.

3. **Upper body dressing:** Individual K sustained a spinal cord injury that has affected both movement and strength in both upper extremities. They place their left hand into one-third of their left sleeve of their shirt with much time and effort and are unable to continue with the activity. A certified nursing assistant then completes the remaining upper body dressing for Individual K.

   Coding: GG0130F would be coded 02, Substantial/maximal assistance.
   Rationale: Individual K can perform a small portion of the activity of upper body dressing but requires assistance by a helper for more than half of the effort of upper body dressing.

Examples for GG0130G, Lower body dressing

1. **Lower body dressing:** Individual D is required to follow hip precautions as a result of recent hip surgery. The occupational therapist in the acute care hospital instructed them in the use of adaptive equipment to facilitate lower body dressing. They require a helper to retrieve their clothing from the closet. Individual D uses their adaptive equipment to assist in threading their legs into their pants.

Because of balance issues, Individual D needs the helper to steady them when standing to manage pulling on or pulling down their pants/undergarments. Individual D also needs some assistance to put on and take off their socks and shoes.

Coding: GG0130G would be coded 04, Supervision or touching assistance.
Rationale: A helper steadies Individual D when they are standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower body dressing.

2. **Lower body dressing:** Individual M has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. They have been issued a knee brace, to be worn during the day. Individual M threads their legs into their garments and pulls up and down their clothing to and from just below their hips. Only a little assistance from a helper is needed to pull up their garments over their hips. Individual M requires the helper to fasten their knee brace because of grasp and fine motor weakness.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.
   Rationale: A helper provides only a little assistance when Individual M is putting on their lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace they wear is considered when determining the help needed when coding lower body dressing.

3. **Lower body dressing:** Individual R has peripheral neuropathy in their upper and lower extremities. Each morning, Individual R needs assistance from a helper to place their lower limb into, or to take it out of (don/doff), their lower limb prosthesis. They need no assistance to put on and remove their underwear or slacks.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.
   Rationale: A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). The helper lifts, holds, or supports Individual R's trunk or limbs, but provides less than half the effort for the task of lower body dressing.

Examples for GG0130H, Putting on/taking off footwear

1. **Putting on/taking off footwear:** Individual M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. They have made significant progress toward their independence and will be discharged to home tomorrow. Individual M wears an ankle-foot orthosis that they put on their foot and ankle after they put on their socks but before they put on their shoes. They always place their AFO, socks, and shoes within easy reach of their bed. While sitting on the bed, they need to bend over to put on and take off their AFO, socks, and shoes, and they occasionally lose their sitting balance, requiring staff to place their hands on them to maintain their balance while performing this task.

   Coding: GG0130H would be coded 04, Supervision or touching assistance.
   Rationale: Individual M puts on and takes off their AFO, socks, and shoes by themself; however, because of occasional loss of balance, they need a helper to provide touching assistance when they are bending over.

2. **Putting on/taking off footwear:** Individual F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. They requiresrequire setup for retrieving their socks and shoes, which they prefer to keep in the closet. Individual F often drops their shoes and socks as they attempt to put them onto their feet or as they take them off. Often a certified nursing assistant must first thread their socks or shoes over their toes, and then Individual F can complete the task. Individual F needs the certified nursing assistant to initiate taking off their socks and unstrapping the fasteners on their shoes.

   Coding: GG0130H would be coded 02, Substantial/maximal assistance.
   Rationale: A helper provides Individual F with assistance in initiating putting on and taking off their footwear because of their limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.

Coding Tips for GG0130I, Personal hygiene

- Complete GG0130I when A0310A = 01 – 06 or A0310F = 10 or 11.
- Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (excludes baths, showers, and oral hygiene).

Examples for GG0130I, Personal hygiene

1. A certified nursing assistant takes Individual L's comb, razor, and shaving cream from the drawer and places them at the bathroom sink. Individual L combs their hair and shaves daily. During the observation period, they required cueing to complete their shaving tasks.

   Coding: GG0130I would be coded 04, Supervision or touching assistance.
   Rationale: A certified nursing assistant placed grooming devices at sink for the individual's use and provided cueing during the observation period.

2. Individual J completed all hygiene tasks independently two out of six times during the observation period. The other four times they were unable to complete brushing and styling their hair and washing and drying their face because of elbow pain after initiating the tasks, so a staff member completed these tasks.

   Coding: GG0130I would be coded 02, Substantial/maximal assistance.
   Rationale: Although Individual J was able to complete their personal hygiene tasks independently on two of the six occasions the activity occurred, a staff member had to complete their personal hygiene tasks after the individual initiated them on four of the six occasions. Because the staff had to complete Individual J's personal hygiene tasks on four of the six occasions the activity occurred during the observation period, the staff provided more than half the effort to complete the personal hygiene tasks.

Examples of Probing Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the individual's eating abilities:

   Nurse: "Please describe to me how Individual S eats their meals. Once the food and liquid are

presented to them, do they use utensils to bring food to their mouth and swallow?"

Certified nursing assistant: "No, I have to feed them."

Nurse: "Do you always have to physically feed them or can they sometimes do some aspect of the eating activity with encouragement or cues to feed themself?"

Certified nursing assistant: "No, they can't do anything by themself. I scoop up each portion of the food and bring the fork or spoon to their mouth. I try to encourage them to feed themself or to help guide the spoon to their mouth but they can't hold the fork. I even tried encouraging them to eat food they could pick up with their fingers, but they will not eat unless they are completely assisted for food and liquid."

In this example, the nurse inquired specifically how Individual S requires assistance to eat their meals. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, they may not have received enough information to make an accurate assessment of the assistance Individual S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

Coding: GG0130A would be coded 01, Dependent.
Rationale: The individual requires complete assistance from the certified nursing assistant to eat their meals.

2. **Oral hygiene:** Example of a probing conversation between a nurse determining an individual's oral hygiene score and a certified nursing assistant regarding the individual's oral hygiene routine:

Nurse: "Does Individual K help with brushing their teeth?"

Certified nursing assistant: "They can help clean their teeth."

Nurse: "How much help do they need to brush their teeth?"

Certified nursing assistant: "They usually gets tired after starting to brush upper teeth. I have to brush most of their teeth."

In this example, the nurse inquired specifically how Individual K manages their oral hygiene. The nurse asked about physical assistance and how the individual performed the activity. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Individual K received.

Coding: GG0130B would be coded 02, Substantial/maximal assistance.
Rationale: The certified nursing assistant provides more than half the effort to complete Individual K's oral hygiene.

GG0170: Mobility (3-day assessment period) Admission

GG0170. Mobility (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170. Mobility (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	1. Admission Performance
	Enter Codes in Boxes ↓
L.	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
M.	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
N.	**4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
O.	**12 steps:** The ability to go up and down 12 steps with or without a rail.
P.	**Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q1. Does the resident use a wheelchair and/or scooter? 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
R.	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR1. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**
S.	**Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS1. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q3. Does the resident use a wheelchair and/or scooter? ☐ 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR3. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS3. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	5. OBRA/Interim Performance
Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter?
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance	
Enter Codes in Boxes ↓	
	Q5. Does the resident use a wheelchair and/or scooter?
☐	0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR5. Indicate the type of wheelchair or scooter used.
☐	1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS5. Indicate the type of wheelchair or scooter used.
☐	1. **Manual** 2. **Motorized**

Item Rationale

- Individuals may have mobility limitations on admission. In addition, individuals may be at risk of further functional decline during their stay in the facility. Please review the item rationale for GG0130, Self-Care, for additional information about the importance of assessing ADLs, including information about health-related quality of life and planning for care.

Steps for Assessment

1. Assess the individual's mobility performance based on direct observation, incorporating individual self-reports and reports from qualified clinicians, care staff, or family documented in the individual's medical record during the assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the individual during the assessment period.
    - For individuals in a Medicare Part A stay, the admission assessment period is the first 3 days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. The admission assessment period for individuals who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600, Entry Date.
        - **Note:** If A0310B = 01 and A0310A = 01 – 06 indicating a five day PPS assessment combined with an OBRA assessment, the assessment period is the first three days of the stay beginning on A2400B. In these scenarios, do not complete Column 5. OBRA/Interim Performance.
    - For individuals in a Medicare Part A stay, the assessment period for the Interim Payment Assessment (A0310B = 08) is the last three days (That is, the ARD plus 2 previous calendar days).
    - For individuals in a Medicare Part A stay, the discharge assessment period is the End Date of Most Recent Medicare Stay (A2400C) plus two previous calendar days. For all other Discharge assessments, the assessment period is A2000, Discharge Date plus two previous calendar days.
    - When completing an OBRA-required assessment other than an Admission assessment (i.e., A0310A =

02 – 06), the assessment period is the ARD plus two previous calendar days.

2. Individuals should be allowed to perform activities as independently as possible, as long as they are safe.
3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (For example, rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because an individual's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. For individuals in a Medicare Part A stay, the admission functional assessment, when possible, should be conducted prior to the individual benefitting from treatment interventions to reflect the individual's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld to conduct the functional assessment.
6. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Individual assessments are to be done in compliance with facility, Federal, and State requirements.

Coding Instructions

When coding the individual's usual performance, use the six-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.

- **Code 06, Independent**: if the individual completes the activity by themself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance**: if the helper sets up or cleans up; individual completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the individual requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.
- **Code 04, Supervision or touching assistance**: if the helper provides verbal cues or touching/steadying/contact guard assistance as individual completes activity. Assistance may be provided throughout the activity or intermittently. For example, the individual requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or individual may require only incidental help such as contact guard or steadying assistance during the activity.
- **Code 03, Partial/moderate assistance**: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the individual requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.
- **Code 02, Substantial/maximal assistance**: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Code 01, Dependent**: if the helper does ALL of the effort. Individual does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the individual to complete the activity.
- **Code 07, Individual refused**: if the individual refused to complete the activity.
- **Code 09, Not applicable**: if the activity was not attempted and the individual did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations**: if the individual did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns**: if the activity was not attempted due to medical condition or safety concerns.

Coding Tips

- **Admission:** The fiveDay PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the individual is admitted for a SNF Part A stay. Additionally, an OBRA Admission assessment (A0310A = 1) is required for a new individual and, under some circumstances, a returning individual and must be completed by the end of day 14. Please refer to Section 2.6 of this Manual for additional information about the OBRA Admission assessment.
    - For the five Day PPS assessment, code the individual's functional status based on a clinical assessment of the individual's performance that occurs soon after the individual's admission. This functional assessment must be completed within the first three days (three calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day three. The admission function scores are to reflect the individual's admission baseline status and are to be based on an assessment. The scores should reflect the individual's status prior to any benefit from interventions. The assessment should occur prior to the individual benefitting from treatment interventions to determine the individual's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld to conduct the functional assessment.
    - For an OBRA Admission assessment, code the individual's usual performance during first three days of their stay starting with the date in A1600, Entry Date.

- **OBRA/Interim:**
    - The Interim Payment Assessment (IPA) (A0310B = 08) is an optional assessment that may be completed by providers to report a change in the individual's PDPM classification.
    - OBRA assessments (A0310A = 01 – 06) are required for individuals in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual.
    - For Section GG on the IPA or an OBRA assessment, providers will use the same 6- point scale and activity not attempted codes to assess the individual's usual functional status during the 3-day assessment period.
    - The ARD for the IPA is determined by the provider, and the assessment period is the last three days (That is, the ARD plus two previous calendar days). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.
    - For Section GG on OBRA assessments other than the admission assessment (That is, A0310A = 02 – 06), the assessment period is the last three days (That is, the ARD plus 2 previous calendar days).

- **Discharge:** The Part A PPS Discharge assessment is required to be completed as a standalone assessment when the individual's Medicare Part A stay ends (as documented in A2400C, End of Most Recent Medicare Stay) and the individual remains in the facility. The Part A PPS Discharge assessment must be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the individual's Discharge Date (A2000). An OBRA Discharge assessment is required when the individual is discharged from the facility. Please see Chapter 2 and Section A of the RAI Manual for additional details regarding Discharge assessments.
    - For the Discharge assessment, (That is, standalone Part A PPS or combined OBRA/Part A PPS), code the individual's discharge functional status, based on a clinical assessment of the individual's performance that occurs as close to the time of the individual's discharge from Medicare Part A as

possible. This functional assessment must be completed within the last three calendar days of the individual's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

- On standalone OBRA Discharge assessments (That is, A0310F = 10 or 11 AND A0310H = 0), code the individual's usual performance during last 3 days of their stay (That is, A2000, Discharge Date plus two previous calendar days).

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the individual, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns, determine the type and amount of assistance required as the individual walks 50 feet and negotiates two turns.
- Individuals with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the individual's need for assistance to perform the activity safely (for example, fall risk due to increased mobility activities).
- An activity can be completed independently with or without devices. If the individual has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.
- If two or more helpers are required to assist the individual to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about an individual's performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG and should be consistent with the clinical assessment documentation in the individual's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.
- CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility activities. Clinical assessments may include any device or equipment that the individual can use to allow them to safely complete the activity as independently as possible.
- Do not code self-care and mobility activities with use of a device that is restricted to individual use during therapy sessions (For example, parallel bars, exoskeleton, or overhead track and harness systems).

Tips for Coding the Individual's Usual Performance

- When coding the individual's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching, verbal cueing, and lifting.

Tips for Coding the Individual's Usual Performance (Continued)

- Do not record the individual's best performance, and do not record the individual's worst performance, but rather record the individual's usual performance during the assessment period.
- Code based on the individual's performance. Do not record the staff's assessment of the individual's potential capability to perform the activity.
- If the individual performs the activity more than once during the assessment period and the individual's performance varies, coding in Section GG is based on the individual's "usual performance," which is identified as the individual's usual activity/performance for any of the Self-Care or Mobility activities, not the

most independent or dependent performance over the assessment period. A provider may need to use the entire assessment period to obtain their usual performance.

Examples and Coding Tips

- The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the individual completing an activity across different times of the day/different days.

Coding Tip for GG0170A, Roll left and right

- If the individual does not sleep in a bed, clinicians should assess bed mobility activities using the alternative furniture on which the individual sleeps (for example, a recliner).

Examples for GG0170A, Roll left and right

1. **Roll left and right:** Mrs. R has a history of skin breakdown. A nurse instructs them to turn onto her right side, providing step-by-step instructions to use the bedrail, bend her left leg, and then roll onto her right side. Mrs. R attempts to roll with the use of the bedrail, but indicates they cannot perform the task. The nurse then rolls them onto her right side. Next, Mrs. R is instructed to return to lying on her back, which they successfully completes. Mrs. R then requires physical assistance from the nurse to roll onto her left side and to return to lying on her back to complete the activity.

   Coding: GG0170A would be coded 02, Substantial/maximal assistance.
   Rationale: The nurse provides more than half of the effort needed for Mrs. R to complete the activity of rolling left and right. This is because the nurse provides physical assistance to move Mrs. R's body weight to turn onto her right side. The nurse provides the same assistance when Mrs. R turns to ther left side and when they return to their back. Mrs. R is able to return to lying on their back from her right side by themself.

2. **Roll left and right:** A physical therapist (PT) helps Mrs. K turn onto her right side by instructing them to bend her left leg and roll onto her right side. The physical therapist then instructs them on how to position her limbs to return to lying on her back and then to repeat a similar process for rolling onto her left side and then return to lying on her back. Mrs. K completes the activity without physical assistance from the physical therapist.

   Coding: GG0170A would be coded 04, Supervision or touching assistance.
   Rationale: The PT provides verbal cues (That is, instructions) to Mrs. K as they roll from their back to their right side and return to lying on their back, and then again as they perform the same activities with respect to their left side. The PT does not provide any physical assistance.

3. **Roll left and right:** Mrs. Z had a stroke that resulted in paralysis on her right side and is recovering from cardiac surgery. They require the assistance of two certified nursing assistants when rolling onto their right side and returning to lying on their back and also when rolling onto ther left side and returning to lying on their back.

   Coding: GG0170A would be coded 01, Dependent.
   Rationale: Two certified nursing assistants are needed to help Mrs. Z roll onto their left and right side and back while in bed.

4. **Roll left and right:** Individual M fell and sustained left shoulder contusions and a fractured left hip and underwent an open reduction internal fixation of the left hip. A physician's order allows them to roll onto their left hip as tolerated. A certified nursing assistant assists Individual M in rolling onto their right side by instructing them to bend their left leg while rolling to their right side. Individual M needs physical assistance from the certified nursing assistant to initiate their rolling right because of their left arm weakness when grasping the right bedrail to assist in rolling. Individual M returns to lying on their back

without assistance and uses their right arm to grasp the left bedrail to slowly roll onto their left hip and then return to lying on their back.

Coding: GG0170A would be coded 03, Partial/moderate assistance.
Rationale: The helper provides less than half the effort needed for the individual to complete the activity of rolling left and right.

Examples for GG0170B, Sit to lying

1. **Sit to lying:** Individual H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on their right side. The helper lifts and positions Individual H's right leg. Individual H uses their arms to position their upper body and lowers themself to a lying position flat on their back.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Individual H's right leg and helps them position it as they move from a seated to a lying position; the helper performs less than half of the effort.

2. **Sit to lying:** Individual F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of their right hip and left and right wrists. The certified nursing assistant cradles and supports their trunk and right leg to transition Individual F from sitting at the side of the bed to lying flat on the bed. Individual F assists themself a small amount by bending their elbows and left leg while pushing their elbows and left foot into the mattress only to straighten their trunk while transitioning into a lying position.

   Coding: GG0170B would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the individual to complete the activity of sit to lying.

3. **Sit to lying:** Individual H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on their right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Individual H each step of the sitting to lying activity. Individual H is then fully assisted to get from sitting to a lying position on the bed. Individual H makes no attempt to assist when asked to perform the incremental steps of the activity.

   Coding: GG0170B would be coded 01, Dependent.
   Rationale: The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the individual to complete an activity, code as 01, Dependent.

Examples for GG0170B, Sit to lying (Continued)

4. **Sit to lying:** Individual F had a stroke about two weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). They can maneuver themself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.

   Coding: GG0170B would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides verbal cues in order for the individual to complete the activity of sit to lying flat on the bed.

5. **Sit to lying:** Individual A suffered multiple vertebral fractures due to a fall off a ladder. They require assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in their lower back. The therapist supports their trunk and lifts both legs to assist Individual A from

sitting at the side of the bed to lying flat on the bed. Individual A assists themself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

Coding: GG0170B would be coded 02, Substantial/maximal assistance.
Rationale: The helper provided more than half the effort for the individual to complete the activity of sit to lying.

Coding Tips for GG0170C, Lying to sitting on side of bed

- The activity includes individual transitions from lying on their back to sitting on the side of the bed without back support. The individual's ability to perform each of the tasks within this activity and how much support the individuals require to complete the tasks within this activity is assessed.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular individual.
- Back support refers to an object or person providing support for the individual's back.
- If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

Examples for GG0170C, Lying to sitting on side of bed

1. **Lying to sitting on side of bed:** Mrs. B pushes up from the bed to get herself from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as Individual B scoots themself to the edge of the bed and lowers their feet onto the floor.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as Mrs. B moves from a lying to sitting position.

2. **Lying to sitting on side of bed:** Individual B pushes up on the bed to attempt to get themself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for them to sit upright. The occupational therapist provides additional lifting assistance as Individual B scoots themself to the edge of the bed and lowers their feet to the floor.

   Coding: GG0170C would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides lifting assistance (more than half the effort) as the individual moves from a lying to sitting position.

3. **Lying to sitting on side of bed:** Individual P is being treated for sepsis and has multiple infected wounds on their lower extremities. Full assistance from the certified nursing assistant is needed to move Individual P from a lying position to sitting on the side of their bed because they usually have pain in their lower extremities upon movement.

   Coding**:** GG0170C would be coded 01, Dependent.
   Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the individual.

4. **Lying to sitting on side of bed:** Individual P is recovering from Guillain-Barre Syndrome with residual lower body weakness. The certified nursing assistant steadies Individual P's trunk as they get to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. Individual P then scoots toward the edge of the bed and places both feet flat on the floor. Individual P completes most of the effort to get from lying to sitting on the side of the bed.

   Coding: GG0170C would be coded 03, Partial/moderate assistance.

Rationale: The helper provided lifting assistance and less than half the effort for the individual to complete the activity of lying to sitting on side of bed.

Coding Tips for GG0170D, Sit to stand

- The activity includes the individual coming to a standing position from any sitting surface.
- If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.
- If a full-body mechanical lift is used to assist in transferring an individual for a chair/bed-to-chair transfer, code GG0170D, Sit to stand with the appropriate "activity not attempted" code.
- Code as 05, Setup or clean-up assistance, if the only help an individual requires to complete the sit-to-stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle-foot orthosis.

Examples for GG0170D, Sit to stand

1. **Sit to stand:** Individual M has osteoarthritis and is recovering from sepsis. Individual M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on Individual M's trunk.

   Coding: GG0170D would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance only.

2. **Sit to stand:** Individual L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist them to stand up from sitting in a chair.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: Individual L requires the assistance of two helpers to complete the activity.

3. **Sit to stand:** Individual B has complete tetraplegia and is currently unable to stand when getting out of bed. They transfer from their bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to their medical condition.

   Coding: GG0170D would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The activity is not attempted due to the individual's diagnosis of complete tetraplegia.

4. **Sit to stand:** Individual Z has amyotrophic lateral sclerosis with moderate weakness in their lower and upper extremities. Individual Z has prominent foot drop in their left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant applies Individual Z's AFO and places the platform walker in front of them; Individual Z uses the walker to steady themself once standing. The certified nursing assistant provides lifting assistance to get Individual Z to a standing position and must also provide assistance to steady Individual Z's balance to complete the activity.

   Coding: GG0170D would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided lifting assistance and more than half of the effort for the individual to complete the activity of sit to stand.

5. **Sit to stand:** Individual R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Individual R their crutches and helps them to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Individual R to a standing position but provides less than half the effort to complete the activity.

Coding: GG0170D would be coded 03, Partial/moderate assistance.
Rationale: The helper provided lifting assistance and less than half the effort for the individual to complete the activity of sit to stand.

Coding Tips for GG0170E, Chair/bed-to-chair transfer

- Depending on the individual's abilities, a transfer may be a stand-pivot, squat-pivot, or slide board transfer.
  - When assessing the individual moving from the chair/bed to the chair, the assessment begins with the individual sitting at the edge of the bed (or alternative sleeping surface) and ends with the individual sitting in a chair or wheelchair.
  - When assessing the individual moving from the chair to the bed, the assessment begins with the individual sitting in a chair or wheelchair and ends with the individual returning to sitting at the edge of the bed (or alternative sleeping surface).
  - The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.
- If a mechanical lift is used to assist in transferring an individual for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the individual assists with any part of the chair/bed-to-chair transfer.
- When possible, the transfer should be assessed in an environmental situation in which taking more than a few steps would not be necessary to complete the transfer.

Examples for GG0170E, Chair/bed-to-chair transfer

1. **Chair/bed-to-chair transfer:** Individual L had a stroke and currently is not able to walk. They use a wheelchair for mobility. When Individual L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position and locks the brakes so that Individual L can transfer into the wheelchair safely. Individual L had been observed several other times to determine any safety concerns, and it was documented that they transfer safely without the need for supervision. They transfer into the wheelchair by themself (no helper) after the certified nursing assistant leaves the room.

   Coding: GG0170E would be coded 05, Setup or clean-up assistance.
   Rationale: Individual L is not able to walk, so they transfer from their bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Individual L transfers safely and does not need supervision or physical assistance during the transfer.

2. **Chair/bed-to-chair transfer:** Individual C is sitting on the side of the bed. They stand and pivot into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time Individual C only required verbal cues for safety, but usually Individual C requires touching assistance.

   Coding: GG0170E would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance during the transfers.

3. **Chair/bed-to-chair transfer:** Individual F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and they recently underwent bilateral above-the-knee amputations. Individual F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Individual F from the bed to a wheelchair. Individual F is unable to assist in the transfer from their bed to the wheelchair.

   Coding: GG0170E would be coded 01, Dependent.
   Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If

two or more helpers are required to assist the individual to complete an activity, code as 01, Dependent.

4. **Chair/bed-to-chair transfer:** Individual P has metastatic bone cancer, severely affecting their ability to use their lower and upper extremities during daily activities. Individual P is motivated to assist with their transfers from the side of their bed to the wheelchair. Individual P pushes themself up from the bed to begin the transfer while the therapist provides limited trunk support with weight-bearing assistance. Once standing, Individual P shuffles their feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance.

   Coding: GG0170E would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half of the effort for the individual to complete the activity of chair/bed-to-chair transfer.

5. **Chair/bed-to-chair transfer:** Mr. U had his left lower leg amputated due to gangrene associated with his diabetes mellitus and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength, but assists with the transfer. The physical therapist assists them in side scooting by lifting his buttocks/trunk in a rocking motion across the transfer board and into the wheelchair.

   Coding: GG0170E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the individual to complete the activity of chair/bed-to-chair transfer.

Coding Tips for GG0170F, Toilet transfer

- Toilet transfer includes the individual's ability to get on and off a toilet (with or without a raised toilet seat) or bedside commode.
- Toileting hygiene, clothing management, and transferring on and off a bedpan are not considered part of the Toilet transfer activity.
- Code as 05, Setup or clean-up assistance, if the individual requires a helper to position/set up the bedside commode before and/or after their bed-to-commode transfers (place at an accessible angle/location next to the bed) and the individual does not require assistance during Toilet transfers.

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant (CNA) moves the wheelchair footrests up so that Mrs. T can transfer from the wheelchair onto the toilet by herself safely. The CNA is not present during the transfer, because supervision is not required. Once Mrs. T completes the transfer from the toilet back to the wheelchair, she flips the footrests back down herself.

   Coding: GG0170F would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (moving the footrest out of the way) before Mrs. T can transfer safely onto the toilet.

2. **Toilet transfer:** The CNA provides steadying (touching) assistance as Mrs. Z lowers their underwear and then transfers onto the toilet. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies them and Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.

   Coding: GG0170F would be coded 04, Supervision or touching assistance.

Rationale: The helper provides steadying assistance as Mrs. Z transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C, Toileting hygiene and is not considered when rating the Toilet transfer item.

3. **Toilet transfer:** The therapist supports Mrs. M's trunk with a gait belt by providing weight-bearing as Mrs. M pivots and lowers herself onto the toilet.

   Coding: GG0170F would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as Mrs. M transferred on and off the toilet.

4. **Toilet transfer:** Mrs. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Mrs. W uses a bedside commode when having a bowel movement. The CNA raises the bed to a height that facilitates the transfer activity. Mrs. W initiates lifting their buttocks from the bed and in addition requires some of her weight to be lifted by the CNA to stand upright. Mrs. W then reaches and grabs onto the armrest of the bedside commode to steady herself. The CNA provides weight-bearing assistance as they slowly rotate and lower Mrs. W onto the bedside commode.

   Coding: GG0170F would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for Mrs. W to complete the activity.

5. **Toilet transfer:** Mrs. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Mrs. H prefers to use the bedside commode when moving their bowels. Due to their severe weakness, history of falls, and dependent transfer status, two CNAs assist during the toilet transfer.

   Coding: GG0170F would be coded 01, Dependent.
   Rationale: The activity required the assistance of two or more helpers for Mrs. H to complete.

6. **Toilet transfer:** Mrs. S is on bedrest due to a medical complication. She uses a bedpan for bladder/bowel management.

   Coding: GG0170F would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: Mrs. S does not transfer onto or off a toilet due to being on bedrest.

Coding Tips for GG0170FF, Tub/shower transfer

- Complete GG0170FF when A0310A = 01 – 06 or A0310F = 10 or 11.
- Tub/shower transfers involve the ability to get into and out of the tub or shower. Do not include washing, rinsing, drying, or any other bathing activities in this item.

Examples for GG0170FF, Tub/shower transfer

1. **Tub/Shower transfer:** During the observation period, Mr. M took one shower. He received physical help from two staff members to get into and out of the shower.

   Coding: GG0170FF would be coded 01. Dependent.
   Rationale: Mr. M required two staff members to assist with shower transfers during the observation period. This represents his usual performance of this activity during the observation period.

2. **Tub/Shower transfer:** On Monday, Mr. Q required trunk support from one CNA to get into and out of the tub. On Wednesday, day 3 of the assessment period, Mr. Q required trunk support from one CNA to get into the tub and needed assistance lifting his legs during the transfer out of the tub. No other tub or shower transfers occurred during the observation period.

   Coding: GG0170FF would be coded 03. Partial/moderate assistance.

Rationale: Mr. Q participated in four tub transfers (two into the tub and two out) during the observation period. He required trunk support for three transfers and required the helper to lift his legs for one. Because the helper performed less than half the effort for three of the four transfers, Mr. Q's usual performance is 03. Partial/moderate assistance.

Coding Tips for GG0170G, Car transfer

- For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers.
- The Car transfer does not include getting to or from the vehicle, opening/closing the car door, or fastening/unfastening the seat belt.
- If the individual remains in a wheelchair and does not transfer in and out of a car or van seat, then the activity is not considered completed, and the appropriate "activity not attempted" code would be used.
- The setup and/or clean-up of an assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding for car transfers.
- In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire assessment period, then use code 10, Not attempted due to environmental limitations.
- If at the time of the assessment the individual is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.

Examples for GG0170G, Car transfer

1. **Car transfer:** Mr. W uses a wheelchair and ambulates for only short distances. He requires lifting assistance from a physical therapist (PT) to get from the wheelchair to a standing position. The PT provides trunk support when Mr. W takes several steps during the transfer turn. Mr. W lowers himself into the car with steadying assistance from the PT. He lifts his legs into the car with support from the PT.

   Coding: GG0170G would be coded 02, Substantial/maximal assistance.
   Rationale: Although Mr. W also contributes effort, the helper contributed more than half the effort needed to transfer Mr. W into the car by providing lifting assistance and trunk support.

2. **Car transfer:** During his rehabilitation stay Mr. N works with an occupational therapist on transfers in and out of the passenger seat. On the day before discharge, Mr. N requires verbal reminders for safety and light touching assistance. The therapist instructs him on strategic hand placement while Mr. N transitions to sitting in the passenger seat. The therapist opens and closes the door.

   Coding: GG0170G would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the Mr. transfers into the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

Coding Tips for GG0170I–GG0170L Walking Items

- Assessment of the walking activities starts with the individual in a standing position.
- A walking activity cannot be completed without some level of individual participation that allows ambulation for the entire stated distance. A helper cannot complete a walking activity for an individual.
- During a walking activity, an individual may take a brief standing rest break. If the individual needs to sit to rest during a Section GG walking activity, consider them "unable to complete" the walking activity.
- Clinicians can use clinical judgment to determine how the actual individual assessment of walking is conducted. If a clinician chooses to combine the assessment of multiple walking activities, the clinician should use clinical judgment to determine the type and amount of assistance needed for each activity.
- Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type

and amount of assistance needed for each individual activity.

- Walking activities do not need to occur during one session. Allowing an individual to rest between activities or completing activities on different days or times during the day may facilitate completion of the activities.
- When coding GG0170 walking items, **do not** consider mobility performance using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.
- The turns included in item GG0170J, Walk 50 ft with two turns, are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two to the left) or may be in different directions (one 90-degree turn to the left and one to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).
- When coding GG0170K, Walk 150 feet, if the individual's environment does not accommodate a walk of 150 feet without turns, but the individual demonstrates the ability to walk, with or without assistance, 150 feet with turns without jeopardizing the individual's safety, code using the 6-point scale.
- When coding GG0170L, Walking 10 feet on uneven surfaces, the activity can be assessed inside or outside. Examples of uneven surfaces include uneven or sloping surfaces, turf, and gravel. Use clinical judgment to determine whether a surface is uneven.

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** Individual C has resolving sepsis and has not walked in three weeks because of their condition. A physical therapist (PT) determines that it is unsafe for Individual C to use a walker, and the individual only walks using the parallel bars. On day 3 of the Admission period, Individual C walks 10 feet using the parallel bars while the PT provides substantial weight-bearing support throughout

   Coding: GG0170I would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: When assessing an individual for GG0170 walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the individual is unable to walk without the use of parallel bars because of their medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concerns.

2. **Walk 10 feet:** Individual L had bilateral amputations three years ago, and prior to the current admission they used a wheelchair and did not walk. Currently Individual L does not use prosthetic devices and uses only a wheelchair for mobility. Individual L's care plan includes fitting and use of bilateral lower extremity prostheses.

   Coding: GG0170I would be coded 09, Not applicable, not attempted and the individual did not perform this activity prior to the current illness, exacerbation, or injury.
   Rationale: When assessing an individual for GG0170I, Walk 10 ft, consider the individual's status prior to the current episode of care and current assessment status. Use code 09, Not applicable, because Individual L did not walk prior to the current episode of care and did not walk during the assessment period.

3. **Walk 10 feet:** Individual C has Parkinson's disease and walks with a walker. A PT must advance the walker for Individual C with each step. The PT assists Individual C by physically initiating the stepping movement forward, advancing Individual C's foot, during the activity of walking 10 feet.

   Coding: GG0170I would be coded 02, Substantial/maximal assistance.
   Rationale: A helper provides more than half the effort as the individual completes the activity.

4. **Walk 10 feet:** Individual O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. A PT assistant guides and steadies the shaking, rolling walker forward while cueing Individual O to take larger steps. Individual O requires steadying at the beginning of the walk and progressively requires some of their weight to be supported for the last two feet of the 10-foot walk.

   Coding: GG0170I would be coded 03, Partial/moderate assistance.

Rationale: The helper provides less than half the effort required for the individual to complete the activity, Walk 10 feet. While the helper guided and steadied the walker during the walk, Individual O supported their own body weight with their arms and legs and propelled their legs forward for 8 of the 10 feet. The helper supported part of Individual O's weight only for 2 of the 10 feet; thus Individual O contributed more than half the effort.

5. **Walk 10 feet:** Individual U has an above-the-knee amputation and severe rheumatoid arthritis. Once a nurse has donned their stump sock and prosthesis, Individual U is assisted to stand and uses their rolling walker while walking. The nurse places their hand on Individual U's back to steady them toward the last half of their 10-foot walk.

   Coding: GG0170I would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides touching assistance in order for the individual to complete the activity of Walk 10 feet. Assistance in donning the stump stock, prosthesis, and getting from a sitting to standing position is not coded as part of the Walk 10 feet item.

Examples for GG0170J, Walk 50 feet with two turns

1. **Walk 50 feet with two turns:** A therapist provides steadying assistance as Individual W gets up from a sitting position to a standing position. After the therapist places Individual W's walker within reach, Individual W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while they walk.

   Coding: GG0170J would be coded 05, Setup or clean-up assistance.
   Rationale: Individual W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D, Sit to stand (04, Supervision or touching assistance)

2. **Walk 50 feet with two turns:** Individual P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when Individual P turns.

   Coding: GG0170J would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the individual walks more than 50 feet and makes two turns. The individual may use an assistive device.

3. **Walk 50 feet with two turns:** Individual L is unable to bear their full weight on their left leg. As they walk 60 feet down the hall with their crutches and make two turns, the certified nursing assistant supports their trunk providing weight-bearing assistance.

   Coding: GG0170J would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides trunk support as the individual walks more than 50 feet and makes two turns.

4. **Walk 50 feet with two turns:** Individual T walks 50 feet with the therapist providing trunk support.Individual Talso requires a second helper, the rehabilitation aide, who provides supervision and follows closely behind with a wheelchair for safety. Individual T walks the 50 feet with two turns with the assistance of two helpers.

   Coding: GG0170J would be coded 01, Dependent.
   Rationale: Individual T requires two helpers to complete the activity.

5. **Walk 50 feet with two turns:** Individual U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Individual U is assisted to stand and, after walking 10 feet, requires progressively more help as they near the 50-foot mark. Individual U is unsteady and typically loses their balance when turning, requiring significant support to remain upright. The therapist provides significant trunk support for about 30 to 35 feet.

Coding: GG0170J would be coded 02, Substantial/maximal assistance.
Rationale: The helper provided more than half of the effort for the individual to complete the activity of walk 50 feet with two turns.

Examples for GG0170K, Walk 150 feet

1. **Walk 150 feet:** Individual D walks down the hall using their walker and the certified nursing assistant usually needs to provide touching assistance to Individual D, who intermittently loses their balance while they use the walker.

   Coding: GG0170K would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance intermittently throughout the activity.

2. **Walk 150 feet:** Individual R has endurance limitations due to heart failure and has only walked about 30 feet during the assessment period. They have not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Individual R.

   Coding: GG0170K would be coded 88, Not attempted due to medical condition or safety concerns, and the individual's ability to walk a shorter distance would be coded in item GG0170I.
   Rationale: The activity was not attempted. The individual did not complete the activity, and a helper cannot complete the activity for the individual. An individual who walks less than 50 feet would be coded in item GG0170I, Walk 10 feet.

3. **Walk 150 feet:** Individual T has an unsteady gait due to balance impairment. Individual T walks the length of the hallway using their quad cane in their right hand. The physical therapist supports their trunk, helping them to maintain their balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance.

   Coding: GG0170K would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort for the individual to complete the activity of walking at least 150 feet.

4. **Walk 150 feet:** Individual W, who has Parkinson's disease, walks the length of the hallway using their rolling walker. The physical therapist provides trunk support and advances Individual W's right leg in longer strides with each step. The therapist occasionally prevents Individual W from falling as they lose their balance during the activity.

   Coding: GG0170K would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort for the individual to complete the activity of walk 150 feet.

Example for GG0170L, Walking 10 feet on uneven surfaces

1. **Walking 10 feet on uneven surfaces:** Mrs. N has severe joint degenerative disease and is recovering from sepsis. Upon discharge Mrs. N will need to be able to walk on the uneven and sloping surfaces of her driveway. During their SNF stay, a PT takes Mrs. N outside to walk on uneven surfaces. Mrs. N requires the PT's weight-bearing assistance less than half the time during walking to prevent Mrs. N from falling as they navigate walking 10 feet over uneven surfaces.

   Coding: GG0170L would be coded 03, Partial/moderate assistance.
   Rationale: Individual N requires a helper to provide weight-bearing assistance several times to prevent them from falling as they walk 10 feet on uneven surfaces. The helper contributes less than half the effort required for Individual N to walk 10 feet on uneven surfaces.

Coding Tips for GG0170M, 1 step (curb); GG0170N, 4 steps; and GG0170O, 12 steps

- Completing the stair activities indicates that an individual goes up and down the stairs, by any safe

means, with or without any assistive devices (for example, railing or stair lift) and with or without some level of assistance. Getting to and from the stairs is not included when coding the curb or step activities.

- Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up the stairs and then down the stairs occurs sequentially, the individual may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps.
- If an individual requires a helper to provide total assist (for example, the individual requires total assist from a helper to move up and down over a curb in their wheelchair), code as 01, Dependent.
- An individual who uses a wheelchair may be assessed going up and down stairs (including one step or curb) in a wheelchair. Code based on the type and amount of assistance required from the helper.
- If, at the time of the assessment, an individual is unable to complete the activity because of a physician-prescribed restriction *of* no stair climbing*, they may be able to complete the stair activities safely by some other means (For example, stair lift, bumping/scooting on their buttocks). If so, code based on the type and amount of assistance required to complete the activity.*
- If, at the time of assessment, an individual is unable to complete the stair activities because of a physician-prescribed bedrest, code the stair activity as "activity not attempted."
- Assess the individual going up and down one step or up and down over a curb. If both are assessed, and the individual's performance going up and down over a curb is different from their performance going up and down one step (For example, because the step has a railing), code GG0170M, 1 step (curb) based on the activity with which the individual requires the most assistance.
- If an individual's environment does not have 12 steps, the combination of going up and down 4 stairs three times consecutively in a safe manner is an acceptable alternative to comply with the intention and meet the requirements of this activity.
- While an individual may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means, without taking more than a brief rest break to consider the stair activity completed.

Example for GG0170M, 1 step (curb)

1. **1 step (curb):** Individual Z has had a stroke; must be able to step up and down one step to enter and exit home. A physical therapist provides standby assistance as they uses their quad cane to support their balance in stepping up one step. The physical therapist provides steadying assistance as Individual Z uses their cane for balance and steps down one step.

   Coding: GG0170M would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides touching assistance as Individual Z completes the activity of stepping up and down one step.

Example for GG0170N, 4 steps

1. **4 steps:** Individual J has lower body weakness, and a physical therapist provides steadying assistance when they ascend four steps. While descending four steps, the physical therapist provides trunk support (more than touching assistance) as Individual J holds the stair railing.

   Coding: GG0170N would be coded 03, Partial/moderate assistance.
   Rationale: A helper provides touching assistance as Individual J ascends 4 steps. The helper provides trunk support (more than touching assistance) when they descend the 4 steps.

Example for GG0170O, 12 steps

1. **12 steps:** Individual Y is recovering from a stroke, resulting in motor issues and poor endurance. Individual Y's home has 12 stairs, with a railing, and they need to use these stairs to enter and exit their home. Their physical therapist uses a gait belt around their trunk and supports less than half of the effort as Individual Y ascends and then descends 12 stairs.

Coding: GG0170O would be coded 03, Partial/moderate assistance.
Rationale: The helper provides less than half the required effort in providing the necessary support for Individual Y as they ascend and descend 12 stairs.

Coding Tips for GG0170P, Picking up object

- The activity includes the individual bending or stooping from a standing position to pick up a small object, such as a spoon, from the floor.
- Picking up the object must be assessed while the individual is in a standing position. If the individual is not able to stand, the activity did not occur, and the appropriate "not attempted" code would be used.
- If a standing individual is unable to pick up a small object from the floor, therefore requiring the helper to assist in picking up the object, code as 01, 02, or 03, depending on whether the helper is providing all the effort, more than half of the effort, or less than half of the effort, respectively.
- Assistive devices and adaptive equipment may be used, for example, a cane to support standing balance and/or a reacher to pick up the object.

Examples for GG0170P, Picking up object

1. **Picking up object:** Individual P has a neurologic condition that has resulted in balance problems. They want to be as independent as possible. Individual P lives with their spouse and will soon be discharged from the SNF. They tend to drop objects and have been practicing bending or stooping from a standing position to pick up small objects, such as a spoon, from the floor. An occupational therapist needs to remind Individual P of safety strategies when they bend to pick up objects from the floor, and the occupational therapist needs to steady them to prevent them from falling.

   Coding: GG0170P would be coded 04, Supervision or touching assistance.
   Rationale: A helper is needed to provide verbal cues and touching or steadying assistance when Individual P picks up an object because of their coordination issues.

2. **Picking up object:** Mr. C has recently undergone a hip replacement. When he drops items, Mr. C uses a long-handled reacher that he has been using at home prior to admission. Mr. C is ready for discharge and can now ambulate with a walker without assistance. When Mr. C drops objects from their walker basket, he requires a certified nursing assistant to locate his long-handled reacher and bring it to him in order for them to use it. Mr. C does not need assistance to pick up the object after the helper brings them the reacher.

   Coding: GG0170P would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides set-up assistance so that Mr. C can use his long-handled reacher.

Coding Tips for GG0170Q, GG0170R, and GG0170S, Wheelchair Items

- The intent of these items is to assess the ability of individuals who are learning how to self-mobilize using a wheelchair or who used a wheelchair prior to admission. Use clinical judgment to determine whether their use of a wheelchair is for self-mobilization as a result of the their medical condition or safety.
- If the individual used a wheelchair for self-mobilization prior to admission to the facility, indicate 1, Yes, to the gateway wheelchair items on the initial assessment in GG0170Q1.
  - The responses for gateway wheelchair items (GG0170Q1, GG0170Q3, and/or GG0170Q5) do not have to be the same on subsequent assessments. For example, the Admission assessment may indicate that the individual does not use a wheelchair but the subsequent assessment may indicate that the individual uses a wheelchair.
- If a wheelchair is used for transport purposes only, then GG0170Q1, GG0170Q3, and/or GG0170Q5, Does the individual use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.

- Example of using a wheelchair for transport convenience: An individual is transported in a wheelchair by staff between their room and the therapy gym or by family to the facility cafeteria, but the individual is not expected to use a wheelchair after discharge.

- The turns included in item GG0170R (wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90- degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level.
- If the environment does not accommodate wheelchair/scooter use for 150 feet without turns, but the individual demonstrates the ability to mobilize a wheelchair or scooter for 150 feet with turns without jeopardizing the individual's safety, code GG0170S, Wheel 150 feet, using the 6-point scale.
- For GG0170S, Wheel 150 feet, a helper can assist an individual in completing the required distance in the wheelchair or in making turns if required. When an individual is unable to wheel the entire distance themself, the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.

Example for GG0170Q1, Does the individual use a wheelchair/scooter?

1. **Does the individual use a wheelchair/scooter?** On admission, Individual T wheels themself using a manual wheelchair, but with difficulty due to their severe osteoarthritis and COPD.

   Coding: GG0170Q1 would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair Individual T uses for GG0170RR1 is indicated as code 1, Manual.
   Rationale: The individual currently uses a wheelchair. Coding the individual's performance and the type of wheelchair (manual) is indicated.

Examples for GG0170R/RR, Wheel 50 ft with two turns and Indicate wheelchair/scooter used

1. **Wheel 50 feet with two turns:** Individual M is unable to bear any weight on their right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring Individual M from the bed into the wheelchair. Once in their wheelchair, Individual M propels themself about 60 feet down the hall using their left leg and makes two turns without any physical assistance or supervision.

   Coding: GG0170R would be coded 06, Independent.
   Rationale: The individual wheels themself more than 50 feet. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

2. **Indicate the type of wheelchair/scooter used:** In the above example Individual M used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Individual M used a manual wheelchair during the assessment period.

3. **Wheel 50 feet with two turns:** Individual R is very motivated to use their motorized wheelchair with an adaptive throttle for speed and steering. Individual R has amyotrophic lateral sclerosis, and moving their upper and lower extremities is very difficult. The physical therapist assistant is required to walk next to Individual R for frequent readjustments of their hand position to better control the steering and speed throttle. Individual R often drives too close to corners, becoming stuck near doorways upon turning, preventing them from continuing to mobilize/wheel themself. The physical therapist assistant backs up Individual R's wheelchair for them so that they may continue mobilizing/wheeling themself.

   Coding: GG0170R would be coded 03, Partial/moderate assistance.

Rationale: The helper provided less than half of the effort for the individual to complete the activity, Wheel 50 feet with two turns.

4. **Indicate the type of wheelchair/scooter used:** In the above example Individual R used a motorized wheelchair during the assessment period.

   Coding: GG0170RR would be coded 2, Motorized.
   Rationale: Individual R used a motorized wheelchair during the assessment period.

5. **Wheel 50 feet with two turns:** Individual V had a spinal tumor resulting in paralysis of their lower extremities. The physical therapist assistant provides verbal instruction for Individual V to navigate their manual wheelchair in their room and into the hallway while making two turns.

   Coding: GG0170R would be coded 04, Supervision or touching assistance.
   Rationale: The helper provided verbal cues for the individual to complete the activity, Wheel 50 feet with two turns.

6. **Indicate the type of wheelchair/scooter used:** In the above example Individual V used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Individual V used a manual wheelchair during the assessment period.

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Individual R wheels about 10 feet in the corridor, then asks the certified nursing assistant to push the wheelchair an additional 40 feet turning into their room and then turning into their bathroom.

   Coding: GG0170R would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort to assist the individual to complete the activity.

8. **Indicate the type of wheelchair/scooter used:** In the above example Individual R used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Individual R used a manual wheelchair during the assessment period.

Examples for GG0170S/SS, Wheel 150 feet and Indicate the type of wheelchair/scooter used

1. **Wheel 150 ft:** Mr. G always uses a motorized scooter to mobilize himself down the hallway and the certified nursing assistant provides cues due to safety issues (to avoid running into the walls).

   Coding: GG0170S would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to complete the activity.

2. **Indicate type of wheelchair/scooter:** In the example above, Mr. G uses a motorized scooter.

   Coding: GG0170SS would be coded 2, Motorized.
   Rationale: Mr. G used a motorized scooter during the assessment period.

3. **Wheel 150 ft:** Mr. N uses a below-the-knee prosthetic limb. He has peripheral neuropathy and limited vision due to complications of diabetes. Mr. N's prior preference was to ambulate within the home and use a manual wheelchair when mobilizing himself within the community. He is assessed, and his usual performance indicates a helper is needed to provide verbal cues for safety due to vision deficits.

   Coding: GG0170S would be coded 04, Supervision or touching assistance.
   Rationale: Mr. N requires the helper to provide verbal cues for their safety when using a wheelchair for 150 feet.

4. **Indicate type of wheelchair/scooter:** In the above example, Mr. N used a manual wheelchair.

   Coding: GG0170SS would be coded 1, Manual.
   Rationale: Mr. N used a manual wheelchair during the assessment period.

5. **Wheel 150 ft:** Mr. L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. He occasionally needs reminders to slow down around the turns and requires assistance from the nurse for backing up the scooter when barriers are present.

   Coding: GG0170S would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort to wheel 150 feet.

6. **Indicate type of wheelchair/scooter:** In the above example, Mr. L used a motorized wheelchair.

   Coding: GG0170SS would be coded 2, Motorized.
   Rationale: Mr. L used a motorized wheelchair during the assessment period.

7. **Wheel 150 ft:** Mr. M has had a mild stroke, resulting in muscle weakness in their right upper and lower extremities. Mr. M uses a manual wheelchair. They usually can self-propel themself about 60 to 70 feet but need assistance from a helper to complete the distance of 150 feet.

   Coding: GG0170S would be coded 02, Substantial/Maximal assistance.
   Rationale: The helper provides more than half of the effort to wheel 150 feet.

8. **Indicate type of wheelchair/scooter:** In the above example, Mr. M used a manual wheelchair.

   Coding: GG0170SS would be coded 1, Manual.
   Rationale: Mr. M used a manual wheelchair during the assessment period.

9. **Wheel 150 feet:** Mr. A has a cardiac condition with medical precautions that does not allow him to propel his own wheelchair. Mr. A is completely dependent on a helper to wheel him 150 feet using a manual wheelchair.

   Coding: GG0170S would be coded 01, Dependent.
   Rationale: The helper provides all the effort and the individual does none of the effort to complete the activity of wheel 150 feet.

10. **Indicate type wheelchair/scooter:** In the above example, Mr. A is wheeled using a manual wheelchair during the assessment period.

    Coding: GG0170SS would be coded 1, Manual.
    Rationale: Mr. A is assisted using a manual wheelchair during the assessment period.

Examples of Probing Conversations with Staff

1. **Sit to lying:** Example of a probing conversation between a nurse determining an individual's score for sit to lying and a certified nursing assistant regarding the individual's bed mobility:

   Nurse: "Please describe how Individual H moves from sitting on the side of the bed to lying flat on the bed. When sitting on the side of the bed, how does they move to lying on their back?"

   Certified nursing assistant: "They can lie down with some help."

   Nurse: "Please describe how much help they need and exactly how you help them."

   Certified nursing assistant: "I have to lift and position their right leg, but once I do that, they can use their arms to position their upper body."

In this example, the nurse inquired specifically about how Individual H moves from a sitting position to a lying position. The nurse asked about physical assistance.

Coding: GG0170B would be coded 03, Partial/moderate assistance.
Rationale: The certified nursing assistant lifts Individual H's right leg and helps them position it as they move from a sitting position to a lying position. The helper does less than half the effort.

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining an individual's score for lying to sitting on side of bed and a certified nursing assistant regarding the individual's bed mobility:

   Nurse: "Please describe how Individual L moves themself in bed. When they are in bed, how do they move from lying on their back to sitting up on the side of the bed?"

   Certified nursing assistant: "They can sit up by themself."

   Nurse: "They sit up without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind them to check on the position of their arm that has limited movement and sensation as they move in the bed, but once I remind to check their arm, they can do it themself."

   In this example, the nurse inquired specifically about how Individual L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.
   Rationale: The certified nursing assistant provides verbal instructions as the individual moves from a lying to sitting position.

3. **Sit to stand:** Example of a probing conversation between a nurse determining an individual's sit to stand score and a certified nursing assistant regarding the individual's sit to stand ability:

   Nurse: "Please describe how Individual L usually moves from sitting on the side of the bed or chair to a standing position. Once they are sitting, how do they get to a standing position?"

   Certified nursing assistant: "They need help to get to sitting up and then standing."

   Nurse: "I'd like to know how much help they need for safely rising up from sitting in a chair or sitting on the bed to get to a standing position."

   Certified nursing assistant: "They need two people to assist them to stand up from sitting on the side of the bed or when they are sitting in a chair."

   In this example, the nurse inquired specifically about how Individual L moves from a sitting position to a standing position and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: Individual L requires the assistance of two helpers to complete the activity.

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining an individual's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the individual's chair/bed-to-chair transfer ability:

Nurse: "Please describe how Individual C moves into the chair from the bed. When they are sitting at the side of the bed, how much help do they need to move from the bed to the chair?"

Certified nursing assistant: "They need me to help them move from the bed to the chair."

Nurse: "Do they help with these transfers when you give them any instructions, setup, or physical help?"

Certified nursing assistant: "Yes, they will follow some of my instructions to get ready to transfer, such as moving their feet from being spread out to placing them under their knees. I have to place the chair close to the bed and then I lift them because they are very weak. I then tell them to reach for the armrest of the chair. Individual C follows these directions and that helps a little in transferring them from the bed to the chair. They do help with the transfer."

In this example, the nurse inquired specifically about how Individual C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cueing instructions. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Individual C received.

Coding: GG0170E would be coded 02, Substantial/maximal assistance.
Rationale: The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the individual's score and a certified nursing assistant regarding an individual's toilet transfer assessment:

Nurse: "I understand that Individual M usually uses a wheelchair to get to their toilet. Please describe how Individual M moves from their wheelchair to the toilet. How do they move from sitting in a wheelchair to sitting on the toilet?"

Certified nursing assistant: "It is hard for them, but they does it with my help."

Nurse: "Can you describe the amount of help in more detail?"

Certified nursing assistant: "I have to give them a bit of a lift using a gait belt to get them to stand and then remind them to reach for the toilet grab bar while they pivot to the toilet. Sometimes, I have to remind them to take a step while they pivot to or from the toilet, but they do most of the effort themself."

In this example, the nurse inquired specifically about how Individual M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Individual M received.

Coding: GG0170F would be coded 03, Partial/moderate assistance.
Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining an individual's score for walking 50 feet with two turns and a certified nursing assistant regarding the individual's walking ability:

Nurse: "How much help does Individual T need to walk 50 feet and make two turns once they are standing?"

Certified nursing assistant: "They need help to do that."

Nurse: "How much help do they need?"

Certified nursing assistant: "They walk about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case they need to sit down."

In this example, the nurse inquired specifically about how Individual T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Individual T received.

Coding: GG0170J would be coded 01, Dependent.
Rationale: Individual T requires two helpers to complete this activity.

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining an individual's score for walking 150 feet and a certified nursing assistant regarding the individual's walking ability:

Nurse: "Please describe how Individual D walks 150 feet in the corridor once they standing."

Certified nursing assistant: "They uses a walker and some help."

Nurse: "They use a walker and how much instructions or physical help do they need?"

Certified nursing assistant: "I have to support them by holding onto the gait belt that is around their waist so that they don't fall. They do push the walker forward most of the time."

Nurse: "Do you help with more than or less than half the effort?"

Certified nursing assistant: "I have to hold onto their belt firmly when they walk because they frequently loses their balance when taking steps. Their balance gets worse the further they walk, but they are very motivated to keep walking. I would say I help them with more than half the effort."

In this example, the nurse inquired specifically about how Individual D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Individual D received.

Coding: GG0170K would be coded 02, Substantial/maximal assistance**.**
Rationale: The certified nursing assistant provides trunk support that is more than half the effort as Individual D walks 150 feet.

8. **Wheel 50 feet with two turns:** Example of a probing conversation between a nurse determining an individual's score for wheel 50 feet with two turns and a certified nursing assistant regarding the individual's mobility:

Nurse: "I understand that Individual R uses a manual wheelchair. Describe to me how Individual R wheels themself 50 feet and makes two turns once they are seated in the wheelchair."

Certified nursing assistant: "They wheels themself."

Nurse: "They wheel themself without any instructions or physical help?"

Certified nursing assistant: "Well yes, they need help to get around turns, so I have to help them and set them on a straight path, but once I do, they wheel themself."

In this example, the nurse inquired specifically about how Individual R wheels 50 feet with two turns.

The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Individual R received.

Coding: GG0170R would be coded 03, Partial/Moderate assistance.
Rationale: The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the individual.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining an individual's score for wheel 150 feet and a certified nursing assistant regarding the individual's mobility:

Nurse: "I understand that Individual G usually uses an electric scooter for longer distances. Once they are seated in the scooter, do they need any help to mobilize themself at least 150 feet?"

Certified nursing assistant: "They drive the scooter themself … they are very slow."

Nurse: "They use the scooter themself without any instructions or physical help?"

Certified nursing assistant: "That is correct."

In this example, the nurse inquired specifically about how Individual G uses an electric scooter to mobilize themself 150 feet. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Individual G received.

Coding: GG0170S would be coded 06, Independent.
Rationale: The individual navigates in the corridor for at least 150 feet without assistance.

SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each individual who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.

H0100: Appliances

Section H	Bladder and Bowel
H0100. Appliances	
↓ Check all that apply	
☐	**A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
☐	**B. External catheter**
☐	**C. Ostomy** (including urostomy, ileostomy, and colostomy)
☐	**D. Intermittent catheterization**
☐	**Z. None of the above**

Definitions

- **Indwelling Catheter -** A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.
- **Suprapubic Catheter -** An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.
- **Nephrostomy Tube -** A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.
- **External Catheter -** Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.
- **Ostomy -** Any type of surgically created opening of the gastrointestinal or gastrourinary tract for discharge of body waste.
- **Urostomy -** A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, For example, after extensive surgery or in case of obstruction.
- **Ileostomy -** A stoma that has been created by bringing the end or loop of the small intestine (the ileum) out onto the surface of the skin.
- **Colostomy -** A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.
- **Intermittent catheterization -** Sterile insertion and removal of a catheter through the urethra for bladder drainage. This includes self- catheterization using clean technique.

Item Rationale

Health-related Quality of Life

- It is important to know what appliances are in use and the history and rationale for such use.
- External catheters should fit well and be comfortable, minimize leakage, maintain skin integrity, and promote individual dignity.
- Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.
- Ostomies (and periostomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote individual dignity.

Planning for Care

- Planning for care should include interventions that are consistent with the individual's goals and minimize complications associated with appliance use.
- Planning for care should be based on an assessment and evaluation of the individual's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, individual's overall condition, risk factors and information about the individual's continence status, catheter status, environmental factors related to continence programs, and the individual's response to catheter/continence services.

Steps for Assessment

1. Examine the individual to note the presence of any urinary or bowel appliances.
2. Review the medical record, if available, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

Check next to each appliance that was used at any time in the past 7 days. Select ***none of the above*** *if none of the appliances A-D were used in the past 7 days.*

- **H0100A,** indwelling catheter (including suprapubic catheter and nephrostomy tube)
- **H0100B,** external catheter
- **H0100C ,** ostomy (including urostomy, ileostomy, and colostomy)
- **H0100D ,** intermittent catheterization
- **H0100Z,** none of the above

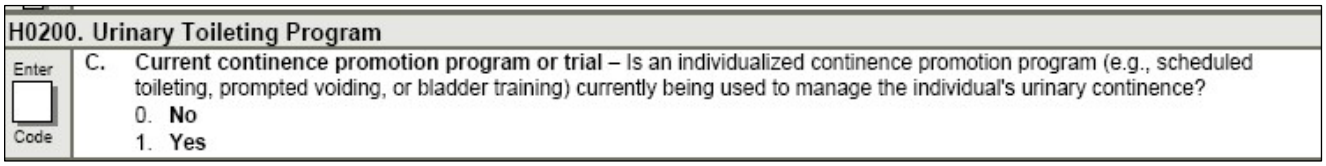
Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- In men, condom catheters, and in females, external urinary pouches, are commonly used

intermittently or at night only. This use should be coded as external catheter.

- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterization for urine specimen during the look-back period as intermittent catheterization

H0200: Urinary Toileting Program



Item Rationale

Health-related Quality of Life

- An individualized, toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- Determining the type of urinary incontinence can allow caregivers to provide more individualized programming or interventions to enhance the individual's quality of life and functional status.
- Many incontinent individuals (including those with dementia) respond to a toileting program, especially during the day.

Planning for Care

- The steps toward ensuring that the individual receives appropriate treatment and services to restore as much bladder function as possible are:
  - Determining if the individual is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
  - Completing an accurate, thorough assessment of factors that may predispose the individual to having urinary incontinence; and
  - Implementing appropriate, individualized interventions and modifying them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one quarter to one third of individuals will have a decrease or resolution of incontinence in response to a toileting program.
- Individuals may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.

Definitions

- **Bladder Rehabilitation/Bladder Retraining** - A behavioral technique that requires the individual to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than the urge to void.
- **Prompted Voiding -** Prompted voiding includes (1) regular monitoring with encouragement to report consistence status, (2) using a schedule and prompting the individual to toilet, and (3) praise and positive feedback when the individual is continent and attempts to toilet.

- **Habit Training/Scheduled Voiding** - A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the individual's voiding habits or needs.

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record, if available, or ask the caregiver for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. The following **three requirements** must have been met:
   - implementation of an individualized, individual-specific toileting program that was based on an assessment of the individual's unique voiding pattern
   - evidence that the individualized program was communicated to the caregiver and the individual (as appropriate) verbally and through a care plan, flow records, and a written report
   - notations of the individual's response to the toileting program and subsequent evaluations, as needed

Coding Instructions H0200C, Current Toileting Program

- **Code 0, no:** if an individualized toileting program (That is, prompted voiding, scheduled toileting, or bladder training) is used less than four days of the 7-day look-back period to manage the individual's urinary continence.
- **Code 1, yes:** for individuals who are being managed, during four or more days of the 7-day look-back period, with some type of systematic toileting program (That is, bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some individuals prefer to not be awakened to toilet. If that individual, however, is on a toileting program during the day, code "yes."

Coding Tips for H0200C

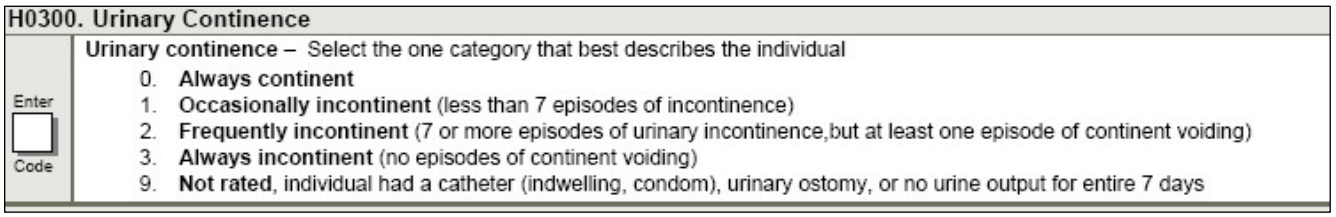
- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with current standards of practice. A toileting program does not refer to:
  - Simply tracking continence status,
  - Changing pads or wet garments, and
  - Random assistance with toileting or hygiene.
- For an individual currently undergoing a trial of a toileting program, H0200C would be **coded 1, current toileting program.**

Example

1. Mrs. H. has a diagnosis of advanced Alzheimer's disease. She is dependent on the caregiver for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding assessment/diary indicates no pattern to her incontinence.

   Coding: H0200C would be coded as 0, no
   Rationale: Since she has impaired cognition with no pattern to her voiding and did not respond to a toileting program, caregiver will provide supportive care.

H0300: Urinary Continence



Definitions

- **Urinary Incontinence -** The involuntary loss of urine.
- **Continence -** Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

Item Rationale

Health-related Quality of Life

- Incontinence can:
  - Interfere with participation in activities,
  - Be socially embarrassing and lead to increased feelings of dependency,
  - Increase risk of long-term institutionalization,
  - Increase risk of skin rashes and breakdown,
  - Increased risk of repeated urinary tract infections, and
  - Increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many individuals, incontinence can be resolved or minimized by
  - Identifying and treating underlying potentially reversible causes, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence);
  - Eliminating environmental physical barriers to accessing commodes, bedpans, and urinals; and
  - Bladder retraining, prompted voiding, or scheduled toileting.
- For individuals whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, there should be a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination, if available.
2. Interview the individual if he or she is capable of reliably reporting his or her continence.
3. Ask the caregiver if the individual has incontinence episodes.

Coding Instructions

- **Code 0, always continent:** if throughout the 7-day look-back period the individual has been

continent of urine, without any episodes of incontinence.

- **Code 1, occasionally incontinent:** if during the 7-day look-back period the individual was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the individual was incontinent of urine during 7 or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.
- **Code 3, always incontinent:** if during the 7-day look-back period, the individual had no continent voids.
- **Code 9, not rated:** if during the 7-day look-back period the individual had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (For example, is on chronic dialysis with no urine output) for the entire 7 days.

Coding Tips and Special Populations

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

Pediatric Tip

- Code "3" always incontinent for an infant or toddler who is incontinent of urine even though it is age appropriate.

Examples

1 Mrs. R an 86-year-old female has had longstanding stress-type incontinence for many years. When she has an upper respiratory infection and is coughing, she involuntarily loses urine. However, during the current 7-day look-back period, she has been free of respiratory symptoms and has not had an episode of incontinence.

Coding: H0300 would be **coded 0, always continent**
Rationale: Even though she has known intermittent stress incontinence, she was continent during the current 7-day look-back period.

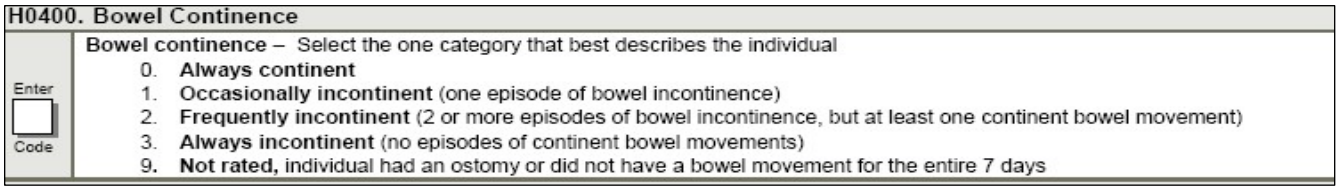
2 Mr. G with multi-infarct dementia is incontinent of urine on three occasions on day one of observation, continent of urine in response to toileting on days two and three, and has one urinary incontinence episode during each of the nights of days four, five, six, and seven of the look-back period.

Coding: H0300 would be **coded as 2, frequently incontinent.**
Rationale: He had seven documented episodes of urinary incontinence over the look-back period. The criterion for "frequent" incontinence has been set at seven or more episodes over the 7-day look-back period with at least one continent void.

3 Mr. V with Parkinson's disease is severely immobile, and cannot be transferred to a toilet. He is unable to use a urinal and is managed by adult briefs and bed pads that are regularly changed. He did not have a continent void during the 7-day look-back period.

Coding: H0300 would be **coded as 3, always incontinent.**
Rationale: He has no urinary continent episodes and cannot be toileted due to severe disability or discomfort. He had one continent urinary void during the 7-day look-back period, after the caregiver assisted him to the toilet and helped with clothing. All other voids were incontinent.

H0400: Bowel Continence



H0400. Bowel Continence	
Enter Code	**Bowel continence** – Select the one category that best describes the individual 0. **Always continent** 1. **Occasionally incontinent** (one episode of bowel incontinence) 2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. **Always incontinent** (no episodes of continent bowel movements) 9. **Not rated,** individual had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
  - Interfere with participation in activities,
  - Be socially embarrassing and lead to increased feelings of dependency,
  - Increase risk of long-term institutionalization,
  - Increase risk of skin rashes and breakdown, and
  - Increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many individuals, incontinence can be resolved or minimized by
  - Identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence); and
  - Eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.
- For individuals whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record, if available, for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination, if available.
2. Interview the individual if he or she is capable of reliably reporting his or her bowel habits.
3. Ask the caregiver if the individual has incontinence episodes.

Coding Instructions

- **Code 0, always continent:** if during the 7-day look-back period the individual has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the individual was incontinent of stool once. This includes incontinence of any amount of stool day or night.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the individual was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
- **Code 3, always incontinent:** if during the 7-day look-back period, the individual was incontinent of bowel for all bowel movements and had no continent bowel movements.

- **Code 9, not rated:** if during the 7-day look-back period the individual had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these individuals should be checked for fecal impaction and evaluated for constipation.)

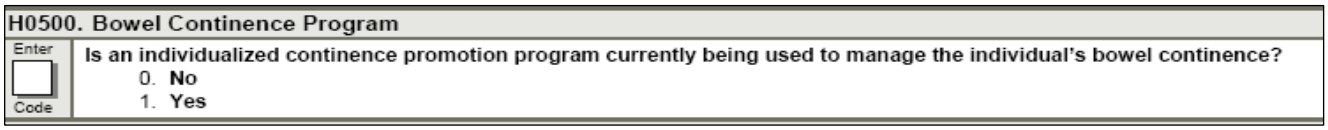
Coding Tips and Special Populations

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Pediatric Tip

- Code "3" always incontinent for an infant or toddler who is incontinent of stool even though it is age appropriate.

H0500: Bowel Continence Program



Item Rationale

Health-related Quality of Life

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences of incontinence.
- Many incontinent individuals respond to a bowel toileting program, especially during the day.

Planning for Care

- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Individuals who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management.
- Individuals with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program the provider/caregiver may want to consider assessing the individual for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement (Newman, 2009).

Steps for Assessment

1. Review the medical record, if available, for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. The following **three requirements** must have been met:
   - Implementation of an individualized, individual-specific bowel toileting program based on an assessment of the individual's unique bowel pattern;
   - Evidence that the individualized program was communicated to the caregiver and the individual (as appropriate) verbally and, if available, through a care plan, flow records, written report; and
   - Notations of the individual's response to the toileting program and subsequent evaluations.

H0600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code ☐	Constipation present? 0. No 1. Yes

Coding Instructions

- **Code 0, no:** if: if the individual is not currently on a toileting program targeted specifically at managing bowel continence.
- **Code 1, yes:** if the individual is currently on a toileting program targeted specifically at managing bowel continence.

Definitions

- **Constipation** - If the individual has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).
- **Fecal Impaction** - A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the individual may be unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of impaction.

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies individuals who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as:
  - Dehydration due to a medical condition or inadequate access to and intake of fluid, and
  - Side effect of medications.

Steps for Assessment

1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, and physical examination, if available, to determine if the individual has had problems with constipation during the 7-day look-back period.
2. Individuals who are capable of reliably reporting their continence and bowel habits should be interviewed.
3. Ask caregivers who routinely work with the individual about problems with constipation.

Coding Instructions

- **Code 0, no:** if the individual shows no fecal impaction or signs of constipation during the 7- day look-back period.
- **Code 1, yes:** if the individual shows signs of constipation or has a fecal impaction during the 7-day look-back period.

Coding Tips and Special Populations

Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

SECTION I: ACTIVE DIAGNOSES

Intent: The items in this section are intended to code diseases that have a direct relationship to the individual's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MN/LOC assessment is to generate an updated, accurate picture of the individual's current health status.

Active Diagnoses in the Last 7 Days

For UTI (I2300) only, the look-back period is 30 days.

Section I Active Diagnoses

Active Diagnoses in the last 7 days – Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

- ☐ I0100. **Cancer** (with or without metastasis)

Heart/Circulation

- ☐ I0200. **Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ I0300. **Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- ☐ I0400. **Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- ☐ I0500. **Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ I0600. **Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ I0700. **Hypertension**

  I0799a. **Blood Pressure** ☐☐☐ ☐☐☐
- ☐ I0800. **Orthostatic Hypotension**
- ☐ I0900. **Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
- ☐ I0999. **Peripheral Edema**

Gastrointestinal

- ☐ I1100. **Cirrhosis**
- ☐ I1200. **Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ I1300. **Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

- ☐ I1400. **Benign Prostatic Hyperplasia (BPH)**
- ☐ I1500. **Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- ☐ I1550. **Neurogenic Bladder**
- ☐ I1650. **Obstructive Uropathy**

Infections

- ☐ I1700. **Multidrug-Resistant Organism (MDRO)**
- ☐ I2000. **Pneumonia**
- ☐ I2100. **Septicemia**
- ☐ I2200. **Tuberculosis**
- ☐ I2300. **Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ I2400. **Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ I2500. **Wound Infection** (other than foot)

Metabolic

- ☐ I2900. **Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)

  I2999. **Blood Sugar Range** ☐☐☐ — ☐☐☐
- ☐ I3100. **Hyponatremia**
- ☐ I3200. **Hyperkalemia**
- ☐ I3300. **Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ I3400. **Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Active Diagnoses in the last 7 days – Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Musculoskeletal

- ☐ I3700. **Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ I3800. **Osteoporosis**
- ☐ I3900. **Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ I3999. **Contractures**
- ☐ I4000. **Other Fracture**
- ☐ I4099. **Scoliosis**

Neurological

- ☐ I4200. **Alzheimer's Disease**
- ☐ I4300. **Aphasia**
- ☐ I4400. **Cerebral Palsy**
- ☐ I4500. **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ I4800. **Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ☐ I4900. **Hemiplegia or Hemiparesis**
- ☐ I5000. **Paraplegia**
- ☐ I5100. **Quadriplegia**
- ☐ I5199. **Tremors**
- ☐ I5200. **Multiple Sclerosis (MS)**
- ☐ I5250. **Huntington's Disease**
- ☐ I5299. **Muscular Dystrophy**
- ☐ I5300. **Parkinson's Disease**
- ☐ I5350. **Tourette's Syndrome**
- ☐ I5399. **Hydrocephalus**
- ☐ I5400. **Seizure Disorder or Epilepsy**

I5499. Type of Seizure

↓ Check all that apply

- ☐ A. **Localized** (partial or focal)
- ☐ B **Generalized** (absence, myclonic, clonic, tonic and atonic)

I5499C. Average Frequency of Seizures in the last 7 days

Enter Code ☐

0. No seizures
1. Less than 1 seizure/week
2. 1-6 seizures/week
3. 1 seizure/day
4. 2-5 seizures/day
5. 6-12 seizures/day
6. More than 12 seizures/day

- ☐ I5500. **Traumatic Brain Injury (TBI)**
- ☐ I5599. **Spina Bifida**

Active Diagnoses in the last 7 days – Check all that apply Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists	
	Nutritional
☐	I5600. **Malnutrition** (protein or calorie) or at risk for malnutrition
☐	I5699. **At risk for dehydration**
	Psychiatric/Mood Disorder
☐	I5700. **Anxiety Disorder**
☐	I5800. **Depression** (other than bipolar)
☐	I5900. **Manic Depression** (bipolar disease)
☐	I5950. **Psychotic Disorder** (other than schizophrenia)
☐	I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
☐	I6100. **Post Traumatic Stress Disorder (PTSD)**
☐	I6199. **ADHD Syndrome**
	Pulmonary
☐	I6200. **Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
☐	I6299. **Cystic Fibrosis**
☐	I6300. **Respiratory Failure**
	Vision
☐	I6500. **Cataracts, Glaucoma, or Macular Degeneration**
	None of Above
☐	I7900. **None of the above active diagnoses** within the last 7 days
	Other
☐	I8000. **Additional active diagnoses** Enter diagnosis description and ICD code. A. _____ ☐☐☐☐☐☐☐☐ B. _____ ☐☐☐☐☐☐☐☐ C. _____ ☐☐☐☐☐☐☐☐ D. _____ ☐☐☐☐☐☐☐☐ E. _____ ☐☐☐☐☐☐☐☐ F. _____ ☐☐☐☐☐☐☐☐ G. _____ ☐☐☐☐☐☐☐☐ H. _____ ☐☐☐☐☐☐☐☐ I. _____ ☐☐☐☐☐☐☐☐ J. _____ ☐☐☐☐☐☐☐☐

Definitions

- **Active Diagnoses –** Physician-documented diagnoses that have a direct relationship to the individual's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
- **Functional Limitations -** Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.
- **Nursing Monitoring** – Nursing Monitoring includes clinical monitoring by a licensed nurse (For example, serial blood pressure evaluations, medication management, etc.)

Item Rationale

Health-Related Quality of Life

- Disease processes can have a significant adverse effect on health status and quality of life.

Planning for Care

- This section identifies active diseases and infections that drive the current plan of care.

Steps for Assessment

Diagnosis status: Active or Inactive status in a 7-day look-back period.

1. **Identify diagnoses:** Review the medical record, if available, for diagnoses
   - Medical record sources include progress notes, the most recent history and physical transfer documents, discharge summaries, diagnosis/problem list, and other resources as available.
2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active.** Active diagnoses are diagnoses that have a direct relationship to the individual's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the individual's current status, or do not drive the plan of care during the 7-day look-back period, as these would be considered inactive diagnosis. Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. For specific coding instructions for Item I2300 UTI please refer to coding tips under Active Diagnoses.
   - **Active** diagnoses have a **direct** relationship to the individual's functional or cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death**.**

Coding Instructions

Code diseases that have a documented diagnosis in the last 7 days and have a relationship to the individual's functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300, UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, for specific coding instructions).

- Document active diagnoses on the MN/LOC as follows:
  - Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary: and Vision.
  - Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, **I0200, Anemia,** includes anemia of any etiology, including those listed (For example, aplastic, iron deficiency, pernicious, sickle cell).
- Check off each active disease. Check all that apply.
- If a disease or condition is **not** specifically listed, enter the ICD code for that diagnosis in item I8000, Additional active diagnoses, and the diagnosis name will auto-fill.
- ICD codes should be "right justified" (aligned with the right margin so that any unused boxes are on the left.
- If a diagnosis is a Z-code, another diagnosis for the related primary medical condition should be checked in items I7900 or entered in I8000.

Cancer

- **I0100,** cancer (with or without metastasis)

Heart/Circulation

- **I0200,** anemia (For example, aplastic, iron deficiency, pernicious, sickle cell)
- **I0300,** atrial fibrillation or other dysrhythmias (For example, bradycardias, tachycardias)
- **I0400,** coronary artery disease (CAD) (For example, angina, myocardial infarction, atherosclerotic heart disease [ASHD])
- **I0500,** deep venous thrombosis (DVT), pulmonary embolus (PE), or pulmonary thrombo-embolism (PTE)
- **I0600,** heart failure (For example, congestive heart failure [CHF], pulmonary edema)
- **I0700,** hypertension - If I0700 is checked
  - If I0700 is checked, entries in I0799a (Blood Pressure Reading) is required. I0799a - The valid values for systolic are 000-300. The valid values for diastolic are 000-200.
- **I0800,** orthostatic hypotension
- **I0900,** peripheral vascular disease or peripheral arterial disease
- **I0999, peripheral edema**

Gastrointestinal

- **I1100,** cirrhosis
- **I1200,** gastroesophageal reflux disease (GERD) or ulcer/injury (For example, esophageal, gastric, and peptic ulcer/injuries)
- **I1300,** Ulcerative colitis or Crohn's disease or inflammatory bowel disease

Genitourinary

- **I1400,** benign prostatic hyperplasia (BPH)
- **I1500,** renal insufficiency, renal failure, or end-stage renal disease (ESRD)
- **I1550,** neurogenic bladder
- **I1650,** obstructive uropathy

Infections

- **I1700,** multidrug resistant organism (MDRO)
- **I2000,** pneumonia
- **I2100,** septicemia
- **I2200,** tuberculosis
- **I2300,** urinary tract infection (UTI) (30-Day Look-back)
- **I2400,** viral hepatitis (For example, hepatitis A, B, C, D, and E)
- **I2500,** wound infection (other than foot)

Metabolic

- **I2900,** diabetes mellitus (DM) (For example, diabetic retinopathy, nephropathy, neuropathy)
  - If I2900 is checked, I2999 (Blood Sugar Range) is required.
  - Valid values for I2999 are 000-999.

- **I2999,** blood sugar range
- **I3100,** hyponatremia
- **I3200,** hyperkalemia
- **I3300,** hyperlipidemia (For example, hypercholesterolemia)
- **I3400,** thyroid disorder (For example, hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

Musculoskeletal

- **I3700,** arthritis (For example, degenerative joint disease (DJD), osteoarthritis, rheumatoid
- arthritis [RA])
- **I3800,** osteoporosis
- **I3900,** hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (For example, subcapital fractures and fractures of the trochanter and femoral neck)
- **I3999**, contractures
- **I4000,** other fracture
- **I4099**, scoliosis

Neurological

- **I4200,** Alzheimer's disease
- **I4300,** aphasia
- **I4400,** cerebral palsy
- **I4500,** cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- **I4800,** Non-Alzheimer's dementia (For example, Lewy-Body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases)
- **I4900,** hemiplegia or hemiparesis
- **I5000,** paraplegia
- **I5100,** quadriplegia
- **I5199,** tremors
- **I5200,** multiple sclerosis (MS)
- **I5250,** Huntington's disease
- **I5299,** muscular dystrophy
- **I5300 ,** Parkinson's disease
- **I5350,** Tourette's syndrome
- **I5399**, hydrocephalus
- **I5400,** seizure disorder or epilepsy
- **I5499 Type of Seizure**
    - Check all that apply
        A. Localized (partial or focal)

B. Generalized (absence, myoclonic, clonic, tonic and atonic)

- **I5499C. Average Frequency of Seizures in the last 7 days**
  0. No seizures
  1. Less than one seizure/week
  2. 1-6 seizures/week
  3. 1 seizure/day
  4. 2-5 seizures/day
  5. 6-12 seizures/day
  6. More than 12 seizures/day

- **I5500,** Traumatic Brain Injury (TBI)
- **I5599,** Spina Bifida

Nutritional

- **I5600,** malnutrition (protein or calorie) or at risk for malnutrition
- **I5699**, at risk for dehydration

Psychiatric/Mood Disorder

- **I5700,** anxiety disorder
- **I5800,** depression (other than bipolar)
- **I5900,** bipolar disorder
- **I5950,** psychotic disorder (other than schizophrenia)
- **I6000,** schizophrenia (For example, schizoaffective and schizophreniform disorders)
- **I6100,** post-traumatic stress disorder (PTSD)
- **I6199** ADHD Syndrome

Pulmonary

- **I6200,** asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (For example, chronic bronchitis and restrictive lung diseases, such as asbestosis)
- **I6299** Cystic Fibrosis
- **I6300,** respiratory failure

Vision

- **I6500,** cataracts, glaucoma, or macular degeneration

None of Above

- **I7900,** none of the above active diagnoses within the past 7 days

Other

- **I8000,** additional active diagnoses

Coding Tips

Sexually Transmitted Disease Reporting- Texas Health & Safety Code § 81.103 prevents the reporting of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) information on the MN/LOC. Do **not** enter the following International Classification of Diseases, Clinical Modification (ICD-10-CM) codes:

- B20 – Human immunodeficiency virus [HIV] disease
- B97.35 – Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere
- O98.711 – Human immunodeficiency virus [HIV] disease complicating pregnancy, first trimester
- O98.712 – Human immunodeficiency virus [HIV] disease complicating pregnancy, second trimester
- O98.713 – Human immunodeficiency virus [HIV] disease complicating pregnancy, third trimester
- O98.719 – Human immunodeficiency virus [HIV] disease complicating pregnancy, unspecified trimester
- O98.72 – Human immunodeficiency virus [HIV] disease complicating childbirth
- O98.73 – Human immunodeficiency virus [HIV] disease complicating the puerperium
- R75 – Inconclusive laboratory evidence of human immunodeficiency virus [HIV]
- Z11.4 - Encounter for screening for human immunodeficiency virus [HIV]
- Z20.6 – Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
- Z21 – Asymptomatic human immunodeficiency virus [HIV] infection status
- Z71.7 – Human immunodeficiency virus [HIV] counseling

Texas does not prohibit the reporting of ICD-10 code Z83.0, family history of [HIV] disease. It was determined that noting the existence of a family member with the disease did not violate the confidentiality of an individual's HIV/AIDS status.

Section I8000 may be completed for other sexually transmitted diseases (STDs) that are not HIV or AIDS or related.

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MN/LOC.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.**
  - The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
  - For example, the physician documents that the individual has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.

- **The listing of a diagnosis/disease on an individual's medical record is not sufficient for determining active or inactive status**. To determine if "arthritis" for example, is an active diagnosis, the nurse assessor would determine if during the 7 day look-back period there were functional limitations caused by the arthritis and treatment for the symptoms of arthritis.

- **In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:**
  - Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge

summaries, doctor's orders, etc.

- Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease. Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease. For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and plans of care, progress notes, etc.
- Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

- **Listing a disease/diagnosis (For example, arthritis) on the individual's medical record problem list is not sufficient for determining active or inactive status**. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.

- **It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice.** For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease.

- **Look-back period for UTI differs from other items, the look-back period is 30 days: Code UTI only if all the following are met**
    1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed practitioner as permitted by state law diagnosis of a UTI in last 30 days,
    2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (For example, peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (For example, pyuria),
    3. "Significant laboratory findings" (The physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and
    4. Current medication or treatment for a UTI in the last 30 days.

- **Regarding individuals with colonized MRSA, the Centers for Disease Control (CDC) provided the following information**: A physician often prescribes empiric antimicrobial therapy for a suspected infection after a culture is obtained, but prior to receiving the culture results. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness of continuation of antimicrobial therapy. This should not be any different, even if the individual is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other microbial resistant organism.

Examples of Active Disease

1. Mr. B is prescribed hydrochlorothiazide for hypertension. He requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen. Physician progress note documents hypertension

   Coding: Hypertension item (I0700), would be **checked**.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

2. Warfarin is prescribed for Ms. D with atrial fibrillation to decrease the risk of embolic stroke. She requires monitoring for change in heart rhythm, for bleeding, and for anticoagulation.

   Coding: Atrial fibrillation item (I0300), would be **checked**.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

3. Ms. L has a past history of healed peptic ulcer/injury is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer/injury disease (PUD) from NSAID treatment.

   Coding: Arthritis item (I3700), would be **checked**.
   Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that she has a history of a healed peptic ulcer/injury without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

4. Mr. H had a stroke four months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior. He is on aspirin and has physical therapy and occupational therapy three times a week. The physician's note 25 days ago lists stroke.

   Coding: Cerebrovascular Vascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke item (I4500), would be **checked.**
   Rationale: The physician note within the last 30 days indicates stroke, and he is receiving medication and therapies to manage continued symptoms from stroke.

Examples of Inactive Diagnoses (do not code)

1. Ms. P had pneumonia two months ago and has recovered completely with no residual effects and no continued treatment during the 7-day look- back period.

   Coding: Pneumonia item (I2000), would **not be checked.**
   Rationale: The pneumonia diagnosis would not be considered active because of her complete recovery and the discontinuation of any treatment during the look-back period.

2. The problem list includes a diagnosis of coronary artery disease (CAD). Mr. O had an angioplasty three years ago, is not symptomatic, and is not taking any medication for CAD.

Coding: CAD item (I0400), would **not be checked.**
Rationale: He has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

3. Mr. J fell and fractured his hip two years ago. At the time of the injury, the fracture was surgically repaired. Following the surgery, he received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker. He also needs help with lower body dressing because of difficulties standing and leaning over.

   Coding: Hip Fracture item (I3900), would **not be checked.**
   Rationale: Although he has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7 day look-back period; thus, Hip Fracture would be considered inactive.

SECTION J: HEALTH CONDITIONS

Intent: The intent of the items in this section is to document a number of health conditions that impact the individual's functional status and quality of life. The items include an assessment of pain which uses an interview with the individual or caregiver if the individual is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, prognosis, problem conditions, and falls.

J0100: Pain Management

(5-Day Look-back)

J0100. Pain Management – Complete for the individual, regardless of current pain level	
At any time in the last 5 days, has the individual:	
Enter Code	**A. Received scheduled pain medication regimen?** 0. **No** 1. **Yes**
Enter Code	**B. Received PRN pain medications OR was offered and declined?** 0. **No** 1. **Yes**
Enter Code	**C. Received non-medication intervention for pain?** 0. **No** 1. **Yes**

Definitions

- **Pain Medication Regimen** – Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.
- **Scheduled Pain Medication Regimen** – A pain medication order that defines dose and specific time interval for pain medication administration, for example, "once a day," "every 12 hours." **PRN Pain Medications** – Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as "every 4 hours as needed for pain" or "every 6 hours as needed for pain."
- **Non-Medication Pain Intervention –** Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal medications are not included in this category.

Item Rationale

Health-related Quality of Life

- Pain can cause suffering and is associated with inactivity, social withdrawal, depression, and functional decline.
- Pain can interfere with participation in rehabilitation.
- Effective pain management interventions can help to avoid these adverse outcomes.

Planning for Care

- Goals for pain management for most individuals should be to achieve a consistent level of comfort while maintaining as much function as possible.
- Identification of pain management interventions, review of the effectiveness of pain management, and revision of the plan if goals are not met.

- Individuals may have more than one source of pain and need a comprehensive, individualized management regimen.
- Most individuals with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as-needed) pain medications for breakthrough pain.
- Some individuals with intermittent or mild pain may have orders for PRN dosing only.
- Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens.
- Interventions must be included as part of a plan of care that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of the plan of care if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.

Step for Assessment

1. Review the medical record, if available, to determine what, if any, pain management interventions the individual received during the five day look-back period. Include information from all disciplines. If the medical record is not available, ask the individual or caregiver.

Coding Instructions for J0100A-C

- Determine all interventions for pain provided to the individual during the 5-day look-back period. Answer these items even if the individual currently denies pain.

Coding Instructions for J0100A, Received Scheduled Pain Medication Regimen

- **Code 0, no:** if the medical record does not contain documentation or the individual/caregiver reports that no scheduled pain medication was received.
- **Code 1, yes:** if the medical record contains documentation or the individual/caregiver reports that a scheduled pain medication was received.

Coding Instructions for J0100B, Received PRN Pain Medication

- **Code 0, no:** if the medical record does not contain documentation or the individual/caregiver reports that no PRN pain medication was received.
- **Code 1, yes:** if the medical record contains documentation or the individual/caregiver reports that a PRN pain medication was either received OR was offered but declined.

Coding Instructions for J0100C, Received Non-medication Intervention for Pain

- **Code 0, no:** if the medical record does not contain documentation or the individual/caregiver reports that no non-medication pain intervention was received.
- **Code 1, yes:** if the medical record contains documentation or the individual/caregiver reports that a non-medication pain intervention was scheduled as part of the plan of care and it is documented that the intervention was actually received and assessed for efficacy.

Coding Tips

- Code only pain medication regimens without PRN pain medications in J0100A. Code receipt of PRN pain medications in J0100B.
- For coding J0100B code only individuals with PRN pain medication regimens here. If the individual has a scheduled pain medication, it should be coded in J0100A.

Examples

1. Mrs. P's caregiver states that she received the following pain management in the past 5 days:
    - Hydrocodone/acetaminophen 5/500 1 tab PO every six hours. Discontinued on day one of look-back period.
    - Acetaminophen 500mg PO every four hours. Started on day two of look-back period.
    - Cold pack to left shoulder applied by PT BID. PT notes that individual reports significant pain improvement after cold pack applied.

    Coding: J0100A would be **coded 1, yes**.
    Rationale: The caregiver stated that she received a scheduled pain medication during the five day look-back period.

    Coding: J0100B would be **coded 0, no**.
    Rationale: The caregiver reported that she declined PRN medications during the five day look-back period.

    Coding: J0100C would be **coded 1, yes**.
    Rationale: The caregiver stated that she received scheduled non-medication pain intervention (cold pack to the left shoulder) during the five day look-back period.

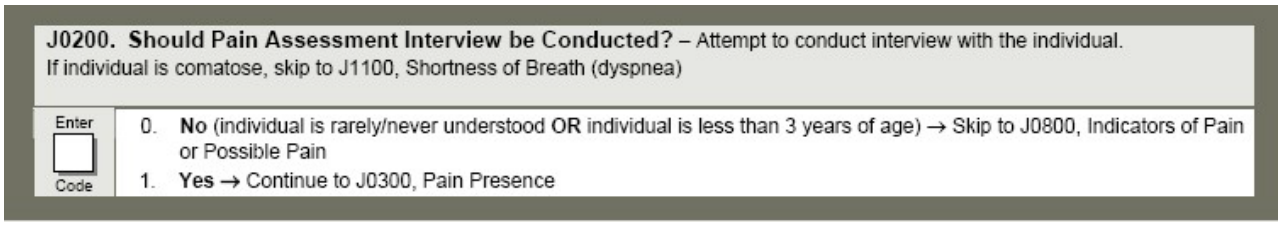
2. Mr. L's medical record includes the following pain management documentation:
    - MS-Contin (morphine sulfate controlled-release) 15 mg PO Q 12 hours: Individual refused every dose of medication during the five day look-back period. No other pain management interventions were documented.

    Coding: J0100A would be **coded 0, no.**
    Rationale: The medical record documented that Mr. L did not receive scheduled pain medication during the five day look-back period. Individuals may refuse scheduled medications; however, medications are not considered "received" if the individual refuses the dose.

    Coding: J0100B would be **coded 0, no**.
    Rationale: The medical record contained no documentation that Mr. L received or was offered and declined any PRN medications during the five day look-back period.

    Coding: J0100C would be **coded 0, no**.
    Rationale: The medical record contains no documentation that Mr. L received non- medication pain intervention during the five day look-back period.

J0200: Should Pain Assessment Interview Be Conducted?



Item Rationale

Health-related Quality of Life

- Most individuals who are capable of communicating can answer questions about how they feel.
- Obtaining information about pain directly from the individual, sometimes called "hearing the individual's voice," is more reliable and accurate than observation alone for identifying pain.
- If an individual cannot communicate (For example, verbal, gesture, written), then caregiver observations for pain behavior (J0800 and J0850) will be used.

Planning for Care

- Interview allows the individual's voice to be reflected in the plan of care.
- Information about pain that comes directly from the individual provides symptom-specific information for the plan of care.

Steps for Assessment

1. Determine whether the individual is understood at least sometimes. Review Language item (A1100), to determine whether the individual needs or wants an interpreter.
2. If an interpreter is needed or requested, every effort should be made to have an interpreter present for the interview.

Coding Instructions

*Attempt to complete the interview if the individual is at least sometimes understood) and an **interpreter is present** or not required.*

- **Code 0, no:** if the individual is rarely/never understood or an interpreter is required but not available. Skip to **Indicators of Pain or Possible Pain** item (J0800).
- **Code 1, yes:** if the individual is at least sometimes understood and an interpreter is present or not required. Continue to **Pain Presence** item (J0300).

Coding Tips and Special Populations

- If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete **Caregiver Assessment of Pain** item (J0800), instead of the **Pain Interview** items (J0300-J0600).

Pediatric Tip:

If the individual is less than three, code "0" and skip to J0800, "Indicators of Pain or Possible Pain."

J0300-J0600: Pain Assessment Interview

Pain Assessment Interview	
J0300. Pain Presence	
Enter ☐ Code	Ask individual: *"Have you had pain or hurting at any time in the last 5 days?"* 0. **No** → Skip to J1100, Shortness of Breath 1. **Yes** → Continue to J0400, Pain Frequency 9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain
J0400. Pain Frequency	
Enter ☐ Code	Ask individual: "*How much of the time have you experienced pain or hurting over the last 5 days?*" 1. **Almost constantly** 2. **Frequently** 3. **Occasionally** 4. **Rarely** 9. **Unable to answer**
J0500. Pain Effect on Function	
Enter ☐ Code	**A.** Ask individual: "*Over the past 5 days, has pain made it hard for you to sleep at night?*" 0. **No** 1. **Yes** 9. **Unable to answer**
Enter ☐ Code	**B.** Ask individual: "*Over the past 5 days, have you limited your day-to-day activities because of pain?*" 0. **No** 1. **Yes** 9. **Unable to answer**
J0600. Pain Intensity – Administer **ONLY ONE** of the following pain intensity questions (A or B)	
Enter ☐☐ Rating	**A. Numeric Rating Scale (00–10)** Ask individual: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show individual 00 -10 pain scale) **Enter two-digit response. Enter 99 if unable to answer.**
Enter ☐ Code	**B. Verbal Descriptor Scale** Ask individual: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show individual verbal scale) 1. **Mild** 2. **Moderate** 3. **Severe** 4. **Very severe, horrible** 9. **Unable to answer**

Definitions

- **Pain** - Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does.
- **Nonsensical response** – Any unrelated, incomprehensible, or incoherent response that is not informative with respect to the item being coded.

Item Rationale

Health-related Quality of Life

- The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired individuals.
- Some older adults limit their activities to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.

Planning for Care

- Directly asking the individual about pain rather than relying on the individual to volunteer the information or relying on observation significantly improves the detection of pain.
- Individual self-report is the most reliable means for assessing pain.
- Pain assessment provides a basis for evaluation treatment need and response to treatment.
- Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential implications for planning of care.

- Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities.
- Pain assessment prompts discussion about factors that aggravate and alleviate pain.
- Similar pain stimuli can have varying impact on different individuals.
- Consistent use of a standardized pain intensity scale improves The validity and reliability of pain assessment. Using the same scale in different settings may improve continuity of care.
- Pain intensity scales allow providers to evaluate whether an individual is responding to pain medication regime(s) and/or non-pharmacological intervention(s).

Steps for Assessment: Basic Instructions for Pain Assessment Interview (J0300-J0600)

1. Interview any individual not screened out by the **Should Pain Assessment Interview be Conducted?** item (J0200).
2. The Pain Assessment Interview for individuals consists of four items: the primary question **Pain Presence** item (J0300), and three follow-up questions **Pain Frequency** item (J0400); **Pain Effect on Function** item (J0500); and **Pain Intensity** item (J0600). If the individual is unable to answer the primary question on pain presenceJ0300, skip to the **Caregiver Assessment for Pain** beginning with **Indicators of Pain or Possible Pain** item (J0800)**.**
3. The look-back period on these items is five days. Because this item asks the individual to recall pain during the past five days, this assessment should be conducted close to the end of the five day look-back period; preferably on the day before, or the assessment date. This should more accurately capture pain episodes that occur during the five day look-back period.
4. Conduct the interview in a private setting.
5. Be sure the individual can hear you.
    - Individuals with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
    - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
    - Minimize background noise.
6. Sit so that the individual can see your face. Minimize glare by directing light sources away from the individual's face.
7. Give an introduction before starting the interview.
    - Suggested language: "I'd like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain."
8. Directly ask the individual each item in J0300 through J0600 in the order provided.
    - Use other terms for pain or follow-up discussion if the individual seems unsure or hesitant. Some individuals avoid use of the term "pain" but may report that they "hurt." Individuals may use other terms such as "aching" or "burning" to describe pain.
9. If the individual chooses not to answer a particular item, accept his or her refusal, **code 9** and move to the next item.
10. If the individual is unsure about whether the pain occurred in the five day time interval, prompt the individual to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.

J0300: Pain Presence

(5-Day Look-Back)

J0300. Pain Presence	
Enter ☐ Code	Ask individual: *"Have you had pain or hurting at any time in the last 5 days?"* 0. **No** → Skip to J1100, Shortness of Breath 1. **Yes** → Continue to J0400, Pain Frequency 9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

Steps for Assessment

1. Ask the individual: "Have you had pain or hurting at any time in the last five days?"

Coding Instructions for J0300, Pain Presence

Code for the presence or absence of pain regardless of pain management efforts during the five day look-back period.

- **Code 0, no:** if the individual responds "no" to any pain in the five day look-back period. **Code 0, no pain**, even if the reason for no pain is that the individual received pain management interventions. If coded 0, the pain interview is complete. Skip to **Shortness of Breath** item (J1100).
- **Code 1, yes:** if the individual responds "yes" to pain at any time during the look-back period. If coded 1, proceed to **Pain Frequency** item (J0400).
- **Code 9, unable to answer:** if the individual is unable to answer, does not respond, or gives a nonsensical response. If coded 9, skip to the Caregiver Assessment for Pain beginning with **Indicators of Pain or Possible Pain** item (J0800).

Coding Tips

- Rates of self-reported pain are higher than observed rates. Although some observers have expressed concern that individuals may not complain and may deny pain, the regular and objective use of self-report pain scales enhances individuals' willingness to report.

Examples

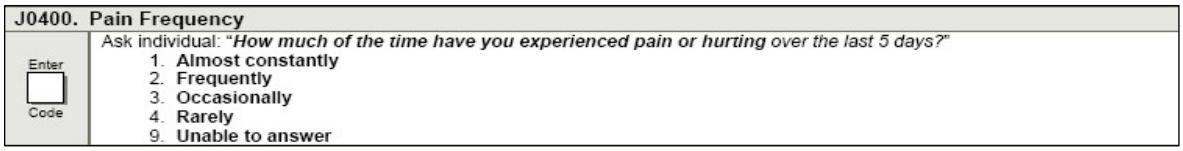
1. When asked about pain, Mrs. S. responds, "No. I have been taking the pain medication regularly, so fortunately I have had no pain."
   Coding: J0300 would be **coded 0, no**. The assessor would skip to **Shortness of Breath** item (J1100)**.**
   Rationale: Mrs. S. reports having no pain during the look-back period. Even though she received pain management interventions during the look-back period, the item is coded "No," because there was no pain.

2. When asked about pain, Mr. T. responds, "No pain, but I have had a terrible burning sensation all down my leg."
   Coding: J0300 would be **coded 1, yes**. The assessor would proceed to **Pain Frequency** item (J0400).
   Rationale: Although Mr. T.'s initial response is "no," the comments indicate that he has experienced pain (burning sensation) during the look-back period.

3. When asked about pain, Ms. G. responds, "I was on a train in 1905."
   Coding: J0300 would be **coded 9, unable to respond.** The assessor would skip to **Indicators of Pain** item (J0800).
   Rationale: Ms. G. has provided a nonsensical answer to the question. The assessor will complete the **Caregiver Assessment for Pain** beginning with **Indicators of Pain** item (J0800).

J0400: Pain Frequency

(5-Day Look-Back)



Steps for Assessment

1. Ask the individual: "How much of the time have you experienced pain or hurting over the last five days?"
2. The nurse assessor may present response options on a written sheet or cue card. This can help the individual respond to the items.
3. If the individual provides a related response but does not use the provided response scale, help clarify the best response by echoing (repeating) the individual's own comment and providing related response options. This interview approach frequently helps the individual clarify which response option he or she prefers.
4. If the individual, despite clarifying statements and repeating response options, continues to have difficulty selecting between two of the provided responses, then select the more frequent of the two.

Coding Instructions

Code for pain frequency during the five day look-back period.

- **Code 1, almost constantly:** if the individual responds "almost constantly" to the question.
- **Code 2, frequently:** if the individual responds "frequently" to the question.
- **Code 3, occasionally:** if the individual responds "occasionally" to the question.
- **Code 4, rarely:** if the individual responds "rarely" to the question.
- **Code 9, unable to answer:** if the individual is unable to respond, does not respond, or gives a nonsensical response. Proceed to items J0500, J0600, and J0700.

Coding Tips

- No predetermined definitions are offered to the individual related to frequency of pain.
  - The response should be based on the individual's interpretation of the frequency options.
  -

Examples

1. When asked about pain, Mrs. C. responds, "All the time. It has been a terrible week. I have not been able to get comfortable for more than 10 minutes at a time since I started physical therapy four days ago."

   Coding: J0400 would be **coded 1, almost constantly**.
   Rationale: Mrs. C. describes pain that has occurred "all the time."

2. When asked about pain, Mr. J. responds, "I don't know if it is frequent or occasional. My knee starts throbbing every time they move me from the bed or the wheelchair." The interviewer says: "Your knee throbs every time they move you. If you had to choose an answer, would you say that you have pain frequently or occasionally?" Mr. J. is still unable to choose between frequently and occasionally.

   Coding: J0400 would be **coded 2, frequently**.
   Rationale: The interviewer appropriately echoed Mr. J.'s comment and provided related response options to help him clarify which response he preferred. Mr. J. remained unable to decide between frequently and occasionally. The interviewer therefore coded for the higher frequency of pain.

3. When asked about pain, Miss K. responds: "I can't remember. I think I had a headache a few times in the past couple of days, but they gave me acetaminophen and the headaches went away." The interviewer clarifies by echoing what Miss K. said: "You've had a headache a few times in the past couple of days and the headaches went away when you were given acetaminophen. If you had to choose from the answers, would you say you had pain occasionally or rarely?" Miss K. replies "Occasionally."

   Coding: J0400 would be **coded 3, occasionally**.
   Rationale: After the interviewer clarified the individual's choice using echoing, the individual selected a response option.

4. When asked about pain, Ms. M. responds, "I would say rarely. Since I started using the patch, I don't have much pain at all, but four days ago the pain came back. I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day."

   Coding: J0400 would be **coded 4, rarely**.
   Rationale: Ms. M. selected the "rarely" response option.

J0500: Pain Effect on Function

(5-Day Look-Back)

J0500. Pain Effect on Function	
Enter ☐ Code	A. Ask individual: *"Over the past 5 days, **has pain made it hard for you to sleep at night?**"* 0. **No** 1. **Yes** 9. **Unable to answer**
Enter ☐ Code	B. Ask individual: *"Over the past 5 days, **have you limited your day-to-day activities because of pain?**"* 0. **No** 1. **Yes** 9. **Unable to answer**

Steps for Assessment

1. Ask the individual each of the two questions exactly as they are written.
2. If the individual's response does not lead to a clear "yes" or "no" answer, repeat the individual's response and then try to narrow the focus of the response. For example, if the individual responded to the question, "Has pain made it hard for you to sleep at night?" by saying, "I always have trouble sleeping," then the assessor might reply, "You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?

Coding Instructions for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?

- **Code 0, no:** if the individual responds "no," indicating that pain did not interfere with sleep.
- **Code 1, yes:** if the individual responds "yes," indicating that pain interfered with sleep.
- **Code 9, unable to answer:** if the individual is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0500B, J0600 and J0700.

Coding Instructions for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?"

- **Code 0, no:** if the individual indicates that pain did not interfere with daily activities.
- **Code 1, yes:** if the individual indicates that pain interfered with daily activities.
- **Code 9, unable to answer:** if the individual is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0600 and J0700.

Pediatric Tips:

J0500A: Ask the child: "Do you wake up at night because you hurt?"
J0500B: Ask the child: "Are there things you would like to do or games you would like to play but can't because they make you hurt?"

Examples for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?

1. Mrs. D responds, "I had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. I slept like a baby."

   Coding: J0500A would be **coded 0, no.**
   Rationale: Mrs. D reports no sleep problems related to pain.

2. Mr. E responds, "I can't sleep at all in this place." The interviewer clarifies by saying, "You can't sleep here. Would you say that was because pain made it hard for you to sleep at night?" Mr. E. responds, "No. It has nothing to do with me. I have no pain. It is because everyone is making so much noise."

   Coding: J0500A would be **coded 0, no.**
   Rationale: Mr. E reports that his sleep problems are not related to pain.

3. Miss G responds, "Yes, the back pain makes it hard to sleep. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."

   Coding: J0500A would be **coded 1, yes.**
   Rationale: Miss G reports pain-related sleep problems.

Examples for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?"

1. Ms. L responds, "No, I had some pain on Wednesday, but I didn't want to miss the shopping trip, so I went."
   Coding: J0500B would be **coded 0, no.**
   Rationale: Although Ms. L reports pain, she did not limit her activity because of it.

2. Mrs. N responds, "Yes, I haven't been able to play the piano, because my shoulder hurts."

   Coding: J0500B would be **coded 1, yes.**
   Rationale: Mrs. N reports limiting her activities because of pain.

3. Mrs. S responds, "I don't know. I have not tried to knit since my finger swelled up yesterday, because I am afraid it might hurt even more than it does now."
   Coding: J0500B would be **coded 1, yes.**
   Rationale: Mrs. S avoided a usual activity because of fear that her pain would increase.

4. Mr. Q responds, "I don't like painful activities." Interviewer repeats question and Mr. Q. responds, "I designed a plane one time."
   Coding: J0500B would be **coded 9, unable to answer.**
   Rationale: Mr. Q has provided a nonsensical answer to the question. Proceed to items J0600 and J0700.

J0600: Pain Intensity

(5-Day Look-Back)

J0600. **Pain Intensity** – Administer ONLY ONE of the following pain intensity questions (A or B)	
Enter ☐☐ Rating	**A. Numeric Rating Scale (00–10)** Ask individual: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show individual 00 -10 pain scale) **Enter two-digit response. Enter 99 if unable to answer.**
Enter ☐ Code	**B. Verbal Descriptor Scale** Ask individual: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show individual verbal scale) 1. **Mild** 2. **Moderate** 3. **Severe** 4. **Very severe, horrible** 9. **Unable to answer**

Steps for Assessment

- You may use either **Numeric Rating Scale** item (J0600A) or **Verbal Descriptor Scale** item (J0600B) to interview the individual about pain intensity.
  - For each individual, try to use the same scale used on prior assessments.
- If the individual is unable to answer using one scale, the other scale should be attempted.

- Record either the Numeric Rating Scale item (J0600A) or the Verbal Descriptor Scale item (J0600B). Leave the response for the unused scale blank.
- Read the question and item choices slowly. While reading, you may show the individual the response options (the "A. Numeric Rating Scale" or "B. Verbal Descriptor Scale") clearly printed on a piece of paper, such as a cue card. Use large, clear print.
    - For A, say, "Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine."
    - For B, say, "Please rate the intensity of your worst pain over the last 5 days."
- The individual may provide a verbal response, point to the written response, or both.

Coding Instructions for J0600A. Numeric Rating Scale (00-10)

Enter the two digit number (00-10) indicated by the individual as corresponding to the intensity of his or her worst pain during the 5-day look-back period, where zero is no pain, and 10 is the worst pain imaginable.

- Enter 99 if unable to answer.
- If the Numeric Rating Scale is not used, leave the response box blank.

Coding Instructions for J0600B. Verbal Descriptor Scale

- **Code 1, mild:** if individual indicates that his or her pain is "mild."
- **Code 2, moderate:** if individual indicates that his or her pain is "moderate."
- **Code 3, severe:** if individual indicates that his or her pain is "severe."
- **Code 4, very severe, horrible:** if individual indicates that his or her pain is "very severe or horrible."
- **Code 9, unable to answer:** if individual is unable to answer, chooses not to respond, does not respond or gives a nonsensical response. Proceed to item J0700.
- If the **Verbal Descriptor Scale, "B,"** is not used, leave the response box blank.

Examples for J0600A. Numeric Rating Scale (00-10)

1. The nurse asks Ms. T. to rate her pain on a scale of 0 to 10. Ms. T. states that she is not sure, because she has shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK. The nurse reminds Ms. T. to think about all the pain she had during the last 5 days and select the number that describes her worst pain. She reports that her pain is a "6."

    Coding: J0600A would be **coded 06**.
    Rationale: Ms. T said her pain was 6 on the 0 to 10 scale. Because a 2-digit number is required, it is entered as 06.

2. The nurse asks Mr. S. to rate his pain, reviews use of the scale, and provides the 0 to 10 visual aid. Mr. S. says, "My pain doesn't have any numbers." The nurse explains that the numbers help his caregivers understand how severe his pain is, and repeats that the "0" end is no pain and the "10" end is the worst pain imaginable. Mr. S. replies, "I don't know where it would fall."

    Coding: Item J0600A would be **coded 99, unable to answer.** The interviewer would go on to ask about pain intensity using the **Verbal Descriptor Scale** item (J0600B).

Rationale: Mrs. S was unable to select a number or point to a location on the 0-10 scale that represented his level of pain intensity.

Examples for J0600B. Verbal Descriptor Scale

1. The nurse asks Mr. R. to rate his pain using the verbal descriptor scale. He looks at the response options presented using a cue card and says his pain is "severe" sometimes, but most of the time it is "mild."

   Coding: J0600B would be **coded 3, severe.**
   Rationale: Mr. R said his worst pain was Severe."

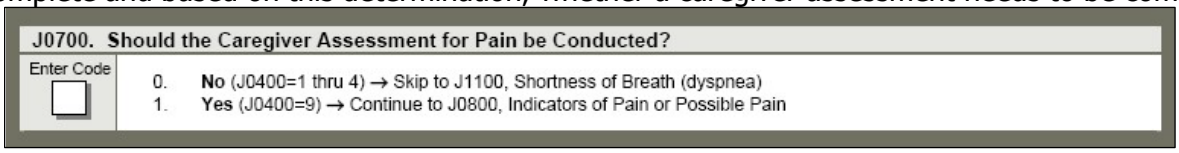
2. The nurse asks Ms. U. to rate her pain, reviews use of the verbal descriptor scale, and provides a cue card as a visual aid. Ms. U. says, "I'm not sure whether it's mild or moderate." The nurse reminds Ms. U. to think about her worst pain during the last 5 days. Ms. U. says "At its worst, it was moderate."

   Coding: Item J0600B would be **coded 2, moderate.**
   Rationale: Ms. U indicated that her worst pain was "Moderate."

J0700: Should the Caregiver Assessment for Pain be Conducted?

(5-Day Look-Back)

Item J0700 closes the pain interview and determine if the individual interview was complete or incomplete and based on this determination, whether a caregiver assessment needs to be completed.



J0700. Should the Caregiver Assessment for Pain be Conducted?	
Enter Code ☐	0. **No** (J0400=1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea) 1. **Yes** (J0400=9) → Continue to J0800, Indicators of Pain or Possible Pain

Definition

- **Completed Interview** – The pain interview is successfully completed if the individual reported no pain (answered no to J0300), or if the individual reported pain (J0300=yes) and the follow-up question J0400 is answered.

Item Rationale

Health-related Quality of Life

- Individual interview for pain is preferred because it improves the detection of pain. However, a small percentage of individuals are unable or unwilling to complete the pain interview.
- Persons unable to complete the pain interview may still have pain.

Planning for Care

- Individual self-report is the most reliable means of assessing pain. However, when an individual is unable to provide the information, caregiver assessment is necessary.
- Even though the individual was unable to complete the interview, important insights may be gained from the responses that were obtained, observing behaviors and observing the individual's affect during the interview.

Steps for Assessment

1. Review the individual's responses to J0200 – J0400.
2. The **Caregiver Assessment for Pain** should only be completed if the **Pain Assessment Interview** (J0200-J0600) was not completed.

Coding Instructions for J0700. Should the Caregiver Assessment for Pain be Conducted? This item is to be coded at the completion of items J0400-J0600.

- **Code 0, no:** if the individual completed the **Pain Assessment Interview** item (J0400 = 1, 2, 3, or 4. Skip to **Shortness of Breath (dyspnea)** item (J1100)**.**
- **Code 1, yes:** if the individual was unable to complete the **Pain Assessment Interview** (J0400 = 9). Continue to **Indicators of Pain or Possible Pain** item (J0800).

Pediatric Tip:

Complete the Caregivers Assessment for Pain if the child is less than 3 years old or if the nurse assessor determines that the child is unable to answer the questions in J0300 – J0600.

J0800: Indicators of Pain

(5-Day Look-Back)

*Complete this item only if the **Pain Assessment Interview** (J0200-J0600) was not completed.*

Caregiver Assessment for Pain	
J0800. Indicators of Pain or Possible Pain in the last 5 days	
↓ Check all that apply	
☐	A. **Non-verbal sounds** (crying, whining, gasping, moaning, or groaning)
☐	B. **Vocal complaints of pain** (that hurts, ouch, stop)
☐	C. **Facial expressions** (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
☐	D. **Protective body movements or postures** (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
☐	Z. **None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

Definitions

- **Non-verbal sounds –** Crying, whining, gasping, moaning, groaning or other audible indications associated with pain.
- **Vocal complaints of pain** – "That hurts," "ouch," "stop," etc.
- **Facial expressions that may be indicators of pain** - Grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw, etc.
- **Protective body movement or postures** – Bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, etc.

Item Rationale

Health-related Quality of Life

- Individuals who cannot verbally communicate about their pain are at particularly high risk for underdetection and undertreatment of pain.
- Severe cognitive impairment may affect the ability of individuals to verbally communicate, thus limiting the availability of self-reported information about pain. In these cognitively impaired

individuals, fewer complaints may not mean less pain.

- Individuals who are unable to verbally communicate may be more likely to use alternative methods of expression to communicate their pain.
- Even in cognitively impaired individuals, some verbal complaints of pain may be made and should be taken seriously.

Planning for Care

- Consistent approach to observation improves the accuracy of pain assessment for individuals who are unable to verbally communicate their pain.
- Identification of these pain indicators can provide a basis for:
  - More comprehensive pain assessment,
  - Determining appropriate treatment, and
  - Ongoing monitoring of pain presence and treatment response.
- If pain indicators are present, assessment should identify aggravating/alleviating factors related to pain.
- Caregivers should carefully monitor, track, and document any possible signs and symptoms of pain.
- Particular attention should be paid to using the indicators of pain during activities when pain is most likely to be demonstrated (For example, bathing, transferring, dressing, walking and potentially during eating).

Steps for Assessment

1. **Review the medical record, if available,** for documentation of each indicator of pain listed in J0800 that occurred during the 5-day look-back period. If the record documents the presence of any of the signs and symptoms listed, confirm your record review with caregivers who work most closely with the individual during ADLs.
2. **Interview caregivers.** Because the medical record may not be available or may fail to note all observable pain behaviors, for any indicators that were not noted as present in medical record review, interview the caregiver who works with the individual during bathing, dressing, transferring, and eating activities. Ask directly about the presence of each indicator that was not noted as being present in the record.
3. **Observe the individual** during care activities. If you observe additional indicators of pain during the 5-day look-back period, code the corresponding items.
   - Observations for pain indicators may be more sensitive if the individual is observed during ADL or wound care.

Coding Instructions

Check all that applied in the past 5 days based on caregiver observation of pain indicators.

- If the medical record review, interview with caregiver, and nurse assessor observation provide no evidence of pain indicators, Check J0800Z, None of these **signs observed or documented**, and proceed to **Shortness of Breath** item (J1100).
- **Check J0800A, non-verbal sounds**: included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported during the look-back period.
- **Check J0800B, vocal complaints of pain:** included but not limited to if the individual was

observed to make vocal complaints of pain (For example, "that hurts," "ouch," or "stop").

- **Check J0800C, facial expressions:** included but not limited to grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw observed or reported during the look-back period.
- **Check J0800D, protective body movements or postures: included but not limited to** if bracing, guarding, rubbing or massaging a body part/area, or clutching or holding a body part during movement were observed or reported during the look-back period.
- **Check J0800Z, none of these signs observed or documented:** if none of these signs were observed or reported during the look-back period.

Coding Tips

- Behavior change, depressed mood, rejection of care and decreased activity participation may be related to pain. These behaviors and symptoms are identified in other sections and not reported here as pain screening items. However, the contribution of pain should be considered when following up on those symptoms and behaviors

Examples

1. Mr. P. has advanced dementia and is unable to verbally communicate. A note in his medical record documents that he has been awake during the last night crying and rubbing his elbow. When interviewing the caregiver, you observe Mr. P. grimacing and clenching his teeth. The caregiver reports that he has been moaning and said "ouch" when she tried to move his arm.

   Coding: Non-verbal Sounds item (J0800A); **Vocal Complaints of Pain** item (J0800B); **Facial Expressions** item (J0800C); and **Protective Body Movements or Postures** item (J0800D), would be **checked**.
   Rationale: Mr. P. has demonstrated vocal complaints of pain (ouch), non-verbal sounds (crying and moaning), facial expression of pain (grimacing and clenched teeth), and protective body movements (rubbing his elbow).

2. Mrs. M. has end-stage Parkinson's disease and is unable to verbally communicate. There is no documentation of pain in her medical record during the 5-day look-back period. The caregivers report that on some mornings she moans and winces when her arms and legs are moved during morning care. During direct observation, you note that Mrs. M. cries and attempts to pull her hand away when the caregiver tries to open the contracted hand to wash it.
   Coding: Non-verbal Sounds items (J0800A); **Facial Expressions** item (J0800C); and **Protective Body Movements or Postures** item (J0800D), would be **checked. Rationale:** Mrs. M. has demonstrated non-verbal sounds (crying, moaning); facial expression of pain (wince), and protective body movements (attempt to withdraw).
3. Mrs. E. has been unable to verbally communicate following a massive cerebrovascular accident (CVA) several months ago and has a Stage 3 pressure ulcer/injury. There is no documentation of pain in her medical record. The caregiver reports that she does not seem to have any pain. You observe the individual during her pressure ulcer/injury dressing change. During the treatment, you observe groaning, facial grimaces, and a wrinkled forehead.

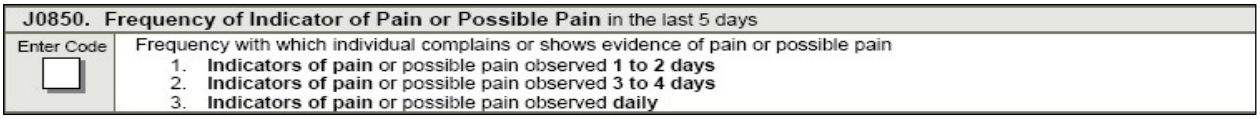
   Coding: Non-verbal Sounds item (J0800A)**,** and **Facial Expressions** item (J0800C), would be **checked**.
   Rationale: Mrs. E has demonstrated non-verbal sounds (groaning) and facial expression of pain (wrinkled forehead and grimacing).

4. Mr. S. is in a persistent vegetative state following a traumatic brain injury. He is unable to verbally communicate. There is no documentation of pain in his medical record during the 5- day look-back period. The caregiver reports that he appears comfortable whenever she cares for him. You observe the caregiver providing morning care and transferring him from bed to chair. No pain indicators are observed at any time.

   Coding: None of These Signs Observed or Documented item (J0800Z) would be **checked**.
   Rationale: All steps for the assessment have been followed and no pain indicators have been documented, reported or directly observed.

J0850: Frequency of Indicator of Pain or Possible Pain

(5-Day Look-Back)



J0850. **Frequency of Indicator of Pain or Possible Pain** in the last 5 days	
Enter Code ☐	Frequency with which individual complains or shows evidence of pain or possible pain 1. **Indicators of pain** or possible pain observed **1 to 2 days** 2. **Indicators of pain** or possible pain observed **3 to 4 days** 3. **Indicators of pain** or possible pain observed **daily**

Item Rationale

Health-related Quality of Life

- Unrelieved pain adversely affects function and mobility contributing to dependence, skin breakdown, contractures, and weight loss.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as to an increase in behavior problems, particularly for cognitively impaired individuals.

Planning for Care

- Assessment of pain frequency provides:
  - A basis for evaluating treatment need and response to treatment.
  - Information to aide in identifying optimum timing of treatment.

Steps for Assessment

1. Interview caregivers to determine the number of days the individual either complained of pain or showed evidence of pain as described in J0800 over the past 5 days.

Coding Instructions

Code for pain frequency over the last 5 days.

- **Code 1:** if based on caregiver observation, the individual complained or showed evidence of pain 1 to 2 days.
- **Code 2:** if based on caregiver observation, the individual complained or showed evidence of pain on 3 to 4 of the last 5 days.
- **Code 3:** if based on caregiver observation, the individual complained or showed evidence of pain on a daily basis.

Examples

1. Mr. M. is an 80-year old male with advanced dementia. During the 5-day look-back period, Mr. M. was noted to be grimacing and verbalizing "ouch" over the past 2 days when his right shoulder was moved.

   Coding: Item J0850 would be **coded 1, indicators of pain observed 1 to 2 days.**
   Rationale: He has demonstrated vocal complaints of pain ("ouch"), facial expression of pain (grimacing) on 2 of the last 5 days.

2. Mrs. C. is a 78-year old female with a history of CVA with expressive aphasia and dementia. During the 5-day look-back period, the individual was noted on a daily basis to be rubbing her right knee and grimacing.

   Coding: Item J0850 would be **coded 3, indicators of pain observed daily.**
   Rationale: Mrs. C was observed with a facial expression of pain (grimacing) and protective body movements (rubbing her knee) every day during the look-back period.

J1100: Shortness of Breath (dyspnea)

Other Health Conditions	
J1100. Shortness of Breath (dyspnea)	
↓ Check all that apply	
☐	A. **Shortness of breath** or trouble breathing **with exertion** (e.g. walking, bathing, transferring)
☐	B. **Shortness of breath** or trouble breathing **when sitting at rest**
☐	C. **Shortness of breath** or trouble breathing **when lying flat**
☐	Z. **None of the above**

Item Rationale

Health-related Quality of Life

- Shortness of breath can be an extremely distressing symptom and lead to decreased interaction and quality of life.
- Some individuals compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath while lying flat by elevating the head of the bed and do not alert caregivers to the problem.

Planning for Care

- Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.
- The plan of care should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

Steps for Assessment

Interview the individual about shortness of breath. Many individuals, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.

1. If the individual is not experiencing shortness of breath or trouble breathing during the interview, ask the individual if shortness of breath occurs when he or she engages in certain activities.

2. Review the medical record, if available, for documentation of the presence of shortness of breath or trouble breathing. Interview the caregiver regarding individual history of shortness of breath, allergies or other environmental triggers of shortness of breath.
3. Observe the individual for shortness of breath or trouble breathing. Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe.
4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

Coding Instructions

Check all that apply during the 7-day look-back period.
Any evidence of the presence of a symptom of shortness of breath should be captured in this item. An individual may have any combination of these symptoms.

- **Check J1100A:** if shortness of breath or trouble breathing is present when the individual is engaging in activity. Shortness of breath could be present during activity as limited as turning or moving in bed during daily care or with more strenuous activity such as transferring, walking, or bathing. If the individual avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.
- **Check J1100B:** if shortness of breath or trouble breathing is present when the individual is sitting at rest.
- **Check J1100C:** if shortness of breath or trouble breathing is present when the individual attempts to lie flat. Also code this as present if the individual avoids lying flat because of shortness of breath.
- **Check J1100Z:** if the individual reports no shortness of breath or trouble breathing and the medical record and/or caregiver interviews indicate that shortness of breath appears to be absent or well controlled with current medication.

Examples

1. Mrs. W. has a diagnosis of chronic obstructive pulmonary disease (COPD) and heart failure. She is on 2 liters of oxygen and daily respiratory treatments. With oxygen she is able to ambulate and participate in most activities. She reports feeling "winded" when walking one or more blocks and has been observed having to stop to rest several times under such circumstances. Recently, she describes feeling "out of breath" when she tries to lie down.

   Coding: J1100A and J1100C would be **checked.**
   Rationale: Mrs. W. reported being short of breath when lying down as well as during outings that required ambulating longer distances.

2. Mr. T. has used an inhaler for years. He is not typically noted to be short of breath. Three days ago, during a respiratory illness, he had mild trouble with his breathing, even when sitting in bed. His shortness of breath also caused him to limit activities.

   Coding: J1100A and J1100B would be **checked.**
   Rationale: Mr. T. was short of breath at rest and was noted to avoid activities because of shortness of breath.

J1400: Prognosis

J1400. Prognosis	
Enter Code ☐	Does the individual have a condition or chronic disease that may result in a **life expectancy of less than 6 months**? 0. **No** 1. **Yes**

Definitions

- **Condition or Chronic Disease** – In the physician's judgment, the individual has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average individual with that level of illness would not be expected to survive more than 6 months. This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single individual. Physician judgment should be based on typical or average life expectancy of individuals with similar level of disease burden as this.
- **Hospice services** – A program for terminally ill persons where an array of services is provided 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. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if an individual is on hospice the expectation is that the documentation is in the medical record.
- **Terminally Ill -** "terminally ill" means the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

Item Rationale

Health-related Quality of Life

- Individuals with conditions or diseases that may result in a life expectancy of less than 6 months have special needs and may benefit from palliative or hospice services.

Planning for Care

- If life expectancy is less than 6 months, an interdisciplinary team plan of care should be based on the individual's preferences for goals and interventions of care whenever possible.

Steps for Assessment

1. Review the medical record, if available, for documentation by the physician that the individual's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness.
2. If a medical record is not available, ask the individual or caregiver if the individual has a condition or chronic disease that may result in a life expectancy of less than 6 months or a terminal illness.
3. If the answer to #2 is yes, the nurse assessor must verify prognosis with the individual's physician (Do not code 1, yes, unless there is documentation available).

Coding Instructions

- **Code 0, no:** if there is no documentation indicating that the individual is terminally ill and the individual is not receiving hospice services.
- **Code 1, yes:** if the medical record includes physician documentation: 1) that the individual is terminally ill; or 2) the individual is receiving hospice services.

Pediatric Tip:
This question should be asked of the parent/caregiver.

Examples

1. Mrs. T. has a diagnosis of heart failure. During the past few months, she has had three hospital admissions for acute heart failure. Her heart has become significantly weaker despite maximum treatment with medications and oxygen. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival beyond the next couple of months is poor.

   Coding: J1400 would be **coded 1, yes**.
   Rationale: The physician documented that her life expectancy is likely to be less than 6 months.

2. Mr. J. was diagnosed with non-small cell lung cancer and is not a candidate for surgical or curative treatment. With his consent, Mr. J. has been referred to hospice by his physician, who documented that his life expectancy was less than 6 months.

   Coding: J1400 would be **coded**
   Rationale: The physician referred the individual's expectancy is likely to be less than 6 months.

J1550: Problem Conditions

J1550. Problem Conditions		
↓ Check all that apply:		
☐	A.	Fever
☐	B.	Vomiting
☐	C.	Dehydrated
☐	D.	Internal bleeding
☐	E99.	Syncope
☐	Z.	None of the above

Definitions

- **Fever – is defined as a temperature 2.4 degrees F higher than baseline.**
- **Vomiting** – Regurgitation of stomach contents; may be caused by many factors (For example, drug toxicity, infection, psychogenic).
- **Internal Bleeding** – Bleeding may be frank (such as bright red blood) or occult (such as guiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds", hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded in internal bleeding.

Item rationale

Health-related Quality of Life

- Timely assessment is needed to identify underlying causes and risk for complications.

Planning for Care

- Implementation of plans of care to treat underlying causes and avoid complications is critical.

Steps for Assessment

1. Review the medical record, if available, interview caregivers, and observe the individual for any indication that the individual had vomiting, fever, potential indicators of dehydration, or internal bleeding during the 7-day look-back period.

Coding Instructions

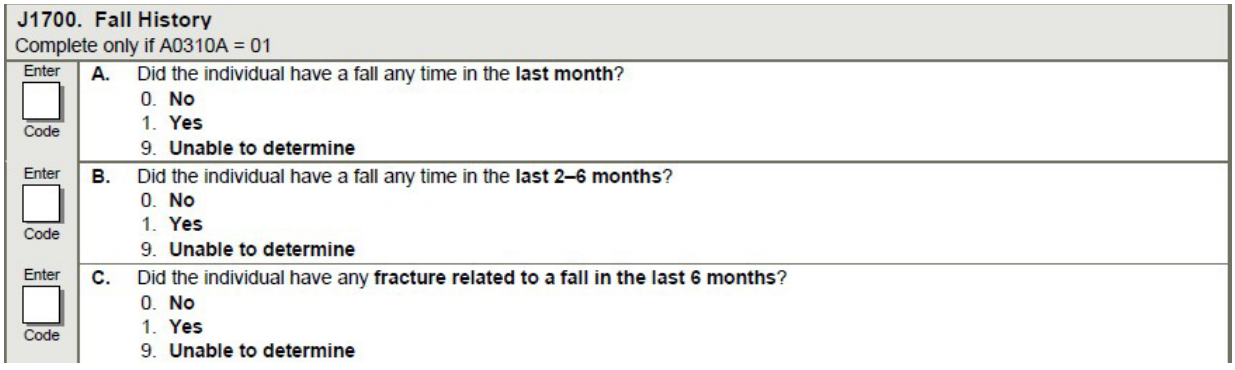
- **J1550A** , fever
- **J1550B ,** vomiting
- **J1550C,** dehydrated
- **J1550D,** internal bleeding
- **J1550E99,** syncope
- **J1550Z,** none of the above

Coding Tips

- **Dehydrated:** Check this item if the individual has two or more of the following indicators:
  - Individual or caregiver reports that the individual usually takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). **Note:** The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
  - Individual or caregiver reports that the individual's fluid loss exceeds the amount of fluids he or she takes in (For example, loss from vomiting, fever, diarrhea that exceeds fluid replacement).
  - The nurse assessor identifies that the individual has one or more potential clinical signs (indicators) of dehydration, including, but not limited to: dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (For example, elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).

Pediatric Tip:
This question should be asked of the parent/caregiver.

J1700: Fall History



J1700. Fall History Complete only if A0310A = 01	
Enter Code	A. Did the individual have a fall any time in the **last month**? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code	B. Did the individual have a fall any time in the **last 2–6 months**? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code	C. Did the individual have any **fracture related to a fall in the last 6 months**? 0. **No** 1. **Yes** 9. **Unable to determine**

Definitions

- **Fall** – Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (For example, onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the individual, caregiver, or identified when an individual is found on the floor or ground. Falls include any fall, no matter where it occurred. Falls are not a result of an overwhelming external force (For example, an individual pushes another individual.) An intercepted fall occurs when the individual would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

- **Fracture Related to a Fall** – Any documented bone fracture (in a problem list from a medical record, an X-ray report, or by history of the individual or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the individual.

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of injury, morbidity, and mortality in older adults.
- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.

Planning for Care

- Determine the potential need for further assessment and intervention, including evaluation of the individual's need for rehabilitation or assistive devices.
- Evaluate the physical environment as well as caregiving needs for individuals who are at risk for falls.

Steps for Assessment

Complete only if A0310 type of assessment is 01 Initial Assessment. The period of review is 180 days (6 months) prior to Initial Assessment, looking back from the individual's assessment date (A2300).

1. Ask the individual or caregiver about a history of falls in the month prior to the Initial Assessment and in the 6 months prior to the Initial Assessment. This would include any fall, no matter where it occurred.
2. Review transfer information (if the individual is being transferred from another setting) for evidence of falls.
3. If available, review all relevant medical records received from other settings where the individual may have resided during the previous 6 months; also review any other medical records received for evidence of one or more falls.

Coding Instructions for J1700A, Did the Individual Have a Fall Any Time in the Last Month?

(30-Day Look-back)

- **Code 0, no:** if individual or caregivers report no falls or records do not document a fall in the last month (A2300).
- **Code 1, yes:** if individual or caregivers report falls or records document a fall in the last month (A2300).
- **Code 9, unable to determine:** if the individual or caregiver is unable to provide the information or records are unavailable or inadequate to determine whether a fall occurred.

Coding Instructions for J1700B, Did the Individual Have a Fall Any Time in the Last 2-6 Months?

(60-180 Day Look-back)

- **Code 0, no:** if individual or caregivers report no falls or records do not document a fall in the last 2-6 months (A2300).
- **Code 1, yes:** if individual or caregivers report falls or records document a fall in the last 2-6 months (A2300).
- **Code 9, unable to determine:** if the individual or caregiver is unable to provide the information, or records are unavailable or inadequate to determine whether a fall occurred.

Coding Instructions for J1700C. Did the Individual Have Any Fracture Related to a Fall in the Last 6 Months?

(180-Day Look-back)

- **Code 0, no:** if individual or caregivers report no fractures related to falls or records do not document a fracture related to fall in the last 6 months (0-180 days) (A2300).
- **Code 1, yes:** if individual or caregivers report or records document a fracture related to fall in the last 6 months (0-180 days) (A2300).
- **Code 9, unable to determine:** if the individual or caregivers is unable to provide the information, or records are unavailable or inadequate to determine whether a fracture occurred related to a fall in the last 6 months.

Pediatric Tip:
J1700A and J1700B: Code reported falls even in situations when the falls are expected, for example, a toddler learning to walk or a child with cerebral palsy.

Examples

1. On assessment interview, Mrs. J. is asked about falls and says she has "not really fallen." However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.

   Coding: J1700A would be **coded 1, yes**.
   Rationale: Falls caused by slipping meet the definition of falls.

2. On assessment interview, an individual denies a history of falling. However, her daughter says that she found her mother on the floor near her toilet twice about 3-4 months ago.

   Coding: J1700B would be **coded 1, yes**.
   Rationale: If the individual is found on the floor, a fall is assumed to have occurred.

3. On assessment interview, Mr. M. and his caregivers deny any history of falling. However, nursing notes in a hospital record document that Mr. M. repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at his bedside to prevent injury the week prior to community setting transfer.

   Coding: J1700A would be **coded 1, yes**.
   Rationale: Medical records from an outside setting document that Mr. M. was found on a mat on the floor. This is defined as a fall.

4. Medical records note that Miss K. had hip surgery 5 months prior to Initial Assessment in a community setting. Miss K.'s daughter says the surgery was needed to fix a broken hip due to a fall.

   Coding: Both J1700B and J1700C would be **coded 1, yes**.
   Rationale: Miss K. had a fall related fracture 1-6 months prior to community setting entry.

5. Mr. O. has a hospital record that includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Mr. O. denies any history of falling.

   Coding: J1700C would be **coded 0, no**.
   Rationale: The fractures were not related to a fall.

6. Ms. P. has a history of a "Colle's fracture" of her left wrist about 3 weeks before Initial Assessment upon entry into a community setting. Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.

   Coding: Both J1700A and J1700C would be **coded 1, yes.**
   Rationale: Ms. P. had a fall-related fracture less than 1 month prior to entry.

J1900: Number of Falls in the last 6 months with or without Injury

(180-Day Look-back)

J1900. Number of Falls in the last 6 months with or without Injury		
Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	☐	A. **No injury** – no evidence of any pain, injury or change in the individual's behavior after the fall as reported by the individual/ caregiver.
	☐	B. **Injury (except major)** – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the individual to complain of pain
	☐	C. **Major injury** – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definitions

- **Injury related to a fall-** Any documented injury attributed to a fall that occurred as a direct result of, or was recognized within a short period of time (For example, hours to a few days) after the fall.
- **Injury (except major) -** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the individual to complain of pain.
- **Major injury -** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among older adults.
- Falls may result in serious injury, especially hip fractures.
- Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

Planning for Care

- Identification of individuals who are at high risk of falling is a top priority for planning of care.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions,
- A fall should stimulate evaluation of the individual's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment.

Steps for Assessment

1. Review the medical record, if available, for any falls occurring in the last 6 months.
2. Review all available sources for any fall occurring in the last 6 months, no matter whether it occurred while away from the community setting, in an acute hospital, or in a facility. Include medical records generated in any health care setting in the last 6 months. All relevant records received from acute and post-acute facilities where the individual may have been admitted during the look-back period should be reviewed for evidence of one or more falls.
3. Review any incident reports for falls and level of injury.
4. Ask the individual and caregivers about falls during the look-back period. Individual and caregiver reports should be captured here, whether or not these incidents are documented in the medical record.

Coding Instructions for J1900

- Determine the number of falls that occurred in the last 6 months and code the level of fall- related injury for each.
- If the individual has multiple injuries in a single fall, code the fall for the highest level of injury.

Coding Instructions for J1900A, No Injury

- **Code 0, none:** if the individual had no falls without injury in the last 6 months.
- **Code 1, one:** if the individual had one fall without injury in the last 6 months.
- **Code 2, two or more:** if the individual had two or more falls in the last 6 months.

Coding Instructions for J1900B, Injury (Except Major)

- **Code 0, none:** if the individual had no falls with injury (except major) in the last 6 months.
- **Code 1, one:** if the individual had one fall with injury (except major) in the last 6 months.
- **Code 2, two or more:** if the individual had two or more falls with injury (except major) in the last 6 months.

Coding Instructions for J1900C, Major Injury

- **Code 0, none:** if the individual had no falls with major injury in the last 6 months.
- **Code 1, one:** if the individual had one fall with major injury in the last 6 months.

- **Code 2, two or more:** if the individual had two or more falls with major injury in the last 6 months.

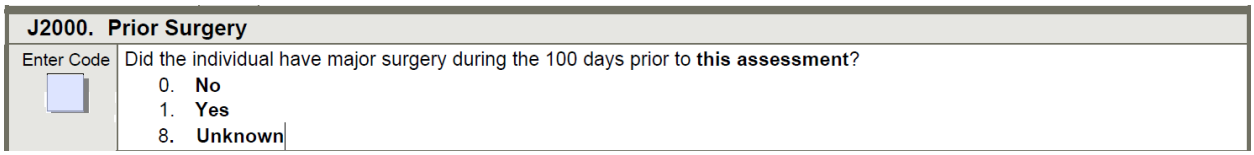
Examples

1. Her caregiver note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her wheelchair, an assessment was completed that indicated no injury.
   Coding: J1900A would be coded 1, one fall with no injury.
   Rationale: Slipping to the floor is a fall. No injury was noted.

2. Ms. Z. went out with her family for dinner. When they returned, her son stated that while at the restaurant, she went to the bathroom and the door closed against her walker, causing her to lose balance and fall. No injury was noted when she returned from dinner.
   Coding: J1900A would be coded 1, one fall with no injury.
   Rationale: Falls occurring even away from the home are captured here.
3. While being treated in the hospital for pneumonia, climbed over his bedrails and fell to the floor. He had a cut over his left eye and some swelling on his arm. X-rays revealed no injury and neurological checks revealed no changes in mental status.
   Coding: J1900B would be coded 1, one fall with injury (except major)
   Rationale: Lacerations and swelling without fracture are classified as injury (except major).

4. An individual fell, lacerated his head, and a CT scan indicated a subdural hematoma.
   Coding: J1900C would be coded as 1, one fall with major injury.
   Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall.

J2000: Prior Surgery



J2000. Prior Surgery	
Enter Code ☐	Did the individual have major surgery during the 100 days prior to **this assessment**? 0. **No** 1. **Yes** 8. **Unknown**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the 100 days prior to this assessment can affect an individual's care and recovery.

Planning for Care

- This item identifies whether the individual has had major surgery during the 100 days prior to this assessment. A recent history of major surgery can affect an individual's care and recovery.

Steps for Assessment

1. Ask the individual and his or her family or significant other about any surgical procedures within the 100 days prior to admission.
2. Review the individual's medical record to determine whether the individual had major surgery during the 100 days prior to admission.

3. *Medical record sources include medical records received from facilities where the individual received health care during the previous 100 days, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.*

Coding Instructions

- Code 0, No, if the individual did not have major surgery during the 100 days prior to the assessment.
- Code 1, Yes, if the individual had major surgery during the 100 days prior to the assessment.
- Code 8, Unknown, if it is unknown or cannot be determined whether the individual had major surgery during the 100 days prior to the assessment.

Coding Tips

Generally, major surgery for item J2000 refers to a procedure that meets **all** the following criteria:

1. the individual was an inpatient in an acute care hospital for at least one day in the 100 days prior to the assessment,
2. the individual had general anesthesia during the procedure, **and**
3. the surgery carried some degree of risk to the individual's life or the potential for severe disability.

Examples

1. Mrs. T reports that she required surgical removal of a skin tag from her neck a month and a half ago. She had the procedure as an outpatient. Mrs. T reports no other surgeries in the last 100 days.

   Coding: J2000 would be coded 0, No.

   Rationale: Mrs. T's skin tag removal surgery did not require an acute care inpatient stay, and general anesthesia was not administered; therefore, the skin tag removal does not meet all three required criteria to be coded as major surgery. Mrs. T did not have any other surgeries in the last 100 days.

2. Mr. A's wife informs his nurse that six months ago he was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis. Mr. A's wife reports Mr. A has had no other surgeries since the time of his bowel resection.

   Coding: J2000 would be coded 0, No.
   Rationale: Bowel resection is a major surgery requiring general anesthesia and has some degree of risk for death or severe disability. Mr. A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and Mr. A has not undergone any surgery since that time.

3. Mrs. G. reports she is receiving Home Health nursing for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy for which she received general anesthesia. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record. The assessment is being performed two days post discharge from the acute care hospitalization. She reports she was in the hospitalization for six days.

   Coding: J2000 would be coded 1, Yes.
   Rationale: Mrs. G underwent a complicated cholecystectomy for which she required general anesthesia. She additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability. Mrs. G required a six-day hospitalization that occurred in the last 100 days.

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Intent: The items in this section are intended to assess the many conditions that could affect the individual's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches.

K0100: Swallowing Disorder

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

Item Rationale

Health-related Quality of Life

- The ability to swallow safely can be affected by many disease processes and functional decline.
- Alterations in the ability to swallow can result in choking and aspiration, which can increase the individual's risk for malnutrition, dehydration, and aspiration pneumonia.

Planning for Care

- When necessary, the individual should be evaluated by the physician, speech language pathologist and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids.
- Assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modifications or other interventions (For example, tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the individual.

Steps for Assessment

1. Ask the individual or the caregiver if the individual has had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D. When possible, observe the individual during meals or at other times when he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorders are exhibited.
2. Interview the caregiver and ask if any of the four listed symptoms were evident during the 7- day look-back period.
3. Review the medical record, if available, including nursing, physician, dietician, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.

Coding Instructions

Check all that apply.

- **K0100A, loss of liquids/solids from mouth when eating or drinking.** When the individual

has food or liquid in his or her mouth, the food or liquid dribbles down chin or falls out of the mouth.

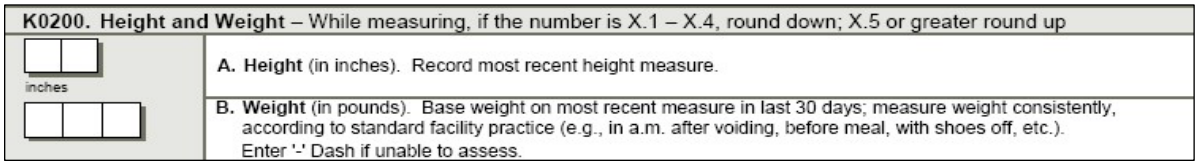
- **K0100B, holding food in mouth/cheeks or residual food in mouth after meals.** Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because individual failed to empty mouth completely.
- **K0100C, coughing or choking during meals or when swallowing medications.** The individual may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The individual may frequently complain of food or medications "going down the wrong way."
- **K0100D, complaints of difficulty or pain with swallowing.** Individual may refuse food because it is painful or difficult to swallow.
- **K0100Z, none of the above:** if none of the K0100A through K0100D signs or symptoms were present during the 7-day look-back period.

Coding Tips

- Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
- Code even if the symptom occurred only once in the 7-day look-back period.

K0200: Height and Weight

(30-Day Look-back for Weight)



K0200. Height and Weight – While measuring, if the number is X.1 – X.4, round down; X.5 or greater round up	
☐☐ inches	A. **Height** (in inches). Record most recent height measure.
☐☐☐	B. **Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.). Enter '-' Dash if unable to assess.

Definitions

- **5 percent Weight loss in 30 Days** – Start with the individual's weight closest to 30 days ago and multiply it by .95 (or 95 percent). The resulting figure represents a 5 percent loss from the weight 30 days ago. If the individual's current weight is equal to or less than the resulting figure, the individual has lost more than 5 percent body weight.
- **10 percent Weight loss in 180 Days** – Start with the individual's weight closest to 180 days ago and multiply it by .90 (or 90 percent). The resulting figure represents a 10 percent loss from the weight 180 days ago. If the individual's current weight is equal to or less than the resulting figure, the individual has lost more than 10 percent body weight.
- **Physician prescribed weight-loss regimen** – A weight reduction plan ordered by the individual's physician with the care plan goal of weight reduction. The regimen may employ a calorie-restricted diet or other weight loss diets and exercise. When a physician has ordered diuretics and weight loss is expected to occur it is included under this definition. It is important that weight loss is intentional.
- **Body mass index (BMI)** – Number calculated from an individual's weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Item Rationale

Health-related Quality of Life

- Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life.

Planning for Care

- Height and weight measurements assist with assessing the individual's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time. The measurement of weight is one guide for determining nutritional status.

Steps for Assessment for K0200A, Height

1. Measure and record height in inches at the time of the Initial and Annual Assessment.
2. Measure height in accordance with current standards of practice (shoes off, etc.).
3. If an individual cannot stand to obtain a current height, height can be measured with the individual lying flat in bed.

Coding Instructions for K0200A, Height

- Record height to the nearest whole inch.
- Use mathematical rounding (That is, if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches.

Steps for Assessment for K0200B, Weight (30-Day Look-back)

1. Measure and record weight in pounds at the time of the Initial and Annual Assessment.
2. If unable to weigh the individual, obtain a medical record that has a recent weight measurement or ask the individual or caregiver and record that measurement.
3. Measure weight in accordance with current standards of clinical practice (For example, after voiding, before meal).

Coding Instructions for K0200B, Weight

- Use mathematical rounding (That is, If weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If an individual cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-).

K0300: Weight Loss

(180-Day Look-back)

K0300. Weight Loss	
Enter Code ☐	**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

Definitions

- **Physician-Prescribed Weight-Loss Regimen**- A weight reduction plan ordered by the individual's physician with the care plan goal of weight reduction. May employ a calorie- restricted diet or other weight loss diets and exercise. When a physician has ordered diuretics and weight loss is expected to occur it is included under this definition. It is important that weight loss is intentional.

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 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 individual's health status or environment.
- If significant unplanned change in weight is noted, the nurse assessor should encourage the individual to make a physician appointment so the individual can be assessed for possible causes of changed intake, changed caloric need, change in medication (For example, diuretics), or changed fluid volume status.

For an Initial Assessment

- Obtain weight from the medical record, if available, or ask the individual or caregiver about weight loss over the past 30 and 180 days.
- If the weight at the Initial Assessment is less than the previous weight, calculate the percentage of weight loss.

For Subsequent Assessments

- Compare the individual's weight to the weight recorded on the previous assessment, or to reported previous weight. If the weight is less, calculate the percentage of weight loss.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight loss calculation.

- **Code 0, no or unknown:** if the individual has not experienced weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days or if information about prior weight is not available.
- **Code 1, yes on physician-prescribed weight loss regimen:** if the individual has experienced a weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where an individual has a weight loss of 5 percent or more in 30 days or 10 percent or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as a **1**.
- **Code 2, yes, not on physician-prescribed weight-loss regimen:** if the individual has experienced a weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight loss was not planned and prescribed by a physician.

Coding Tips

- Weight changes of 5 percent in 1 month, 7.5 percent in 3 months, or 10 percent in 6 months should prompt a thorough assessment of the individual's nutritional status.
- To code K0300 as **1, yes**, the expressed goal of the diet must be inducing weight loss or the expected weight loss of edema through the use of diuretics.
- On occasion, an individual with normal BMI or even low BMI is placed on a diabetic or otherwise calorie-restricted diet. In this instance, the intent of the diet is not to induce weight loss, and it would not be considered a physician-ordered weight-loss regimen.

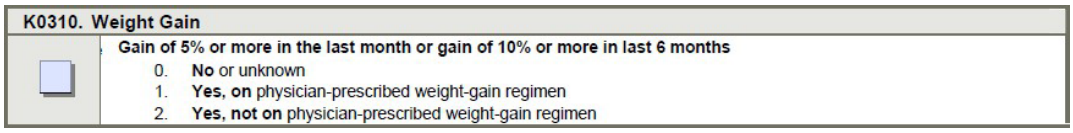
Examples

1. Mrs. J has been on a physician ordered calorie-restricted diet for the past year. She and her physician agreed to a plan of weight reduction. Her current weight is 169 lbs. Her weight 30 days ago was 172 lbs. Her weight 180 days ago was 192 lbs.
   Coding: K0300 would be coded 1, yes, on physician-prescribed weight-loss regimen.
   Rationale: See a 30 and 180 day calculation below:
   - 30-day calculation: 172 x 0.95 = 163.4. Since the individual's current weight of 169 lbs. is more than 163.4 lbs., which is the 5 percent point, she **has not** lost 5 percent body weight in the last 30 days.
   - 180-day calculation: 192 x .90 = 172.8. Since the individual's current weight of 169 lbs. ***is*** less than 172.8 lbs., which is the 10 percent point, she **has** lost 10 percent or more of body weight in the last 180 days.

2. Mr. S has had increasing need for assistance with eating over the past 6 months. His current weight is 195 lbs. His weight 30 days ago was 197 lbs. His weight 180 days ago was 185 lbs.
   Coding: K0300 would be **coded 0, no.**
   Rationale: See a 30 and 180 day calculation below:
   - 30-day calculation: 197 x 0.95 = 187.15. Because the individual's current weight of 195 lbs. is more than 187.15 lbs., which is the 5 percent point, he has not lost 5 percent body weight in the last 30 days.
   - 180-day calculation: Mr. S's current weight of 195 lbs. is greater than his weight 180 days ago, so there is no need to calculate his weight loss. He has gained weight over this time period.

K0310: Weight Gain

(180-Day Look-back)



Item Rationale

Health-related Quality of Life

- Weight gain can result in debility and adversely affect health, safety, and quality of life.

Planning for Care

- Weight gain may be an important indicator of a change in the individual's health status or environment

- If significant weight gain is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (For example, steroidals), or changed fluid volume status.
- Weight gain should be monitored on a continuing basis, assessed and care planned.

For an Initial Assessment

- Obtain weight from the medical record, if available, or ask the individual or caregiver about weight gain over the past 30 and 180 days.
- If the weight at the Initial Assessment is less than the previous weight, calculate the percentage of weight gain.

For Subsequent Assessments

- Compare the individual's weight to the weight recorded on the previous assessment, or to reported previous weight. If the weight is more, calculate the percentage of weight gain.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight gain calculation.

- **Code 0, no or unknown:** if the individual has not experienced weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days or if information about prior weight is not available.
- **Code 1, yes on physician-prescribed weight gain regimen:** if the individual has experienced a weight gain of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where an individual has a weight gain of 5 percent or more in 30 days or 10 percent or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as a **1.**
- **Code 2, yes, not on physician-prescribed weight-gain regimen:** if the individual has experienced a weight gain of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

Coding Tips

- Weight changes of 5 percent in 1 month, 7.5 percent in 3 months, or 10 percent in 6 months should prompt a thorough assessment of the individual's nutritional status.
- To code K0310 as **1, yes**, the expressed goal of the weight gain diet must be documented.

K0510: Nutritional Approaches

K0510. Nutritional Approaches	
↓ Check all of the following nutritional approaches that were performed during the last 7 days	
☐	A. **Parenteral/IV feeding**
☐	B. **Feeding-tube** – nasogastric or abdominal (PEG)
☐	C. **Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
☐	D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
☐	Z. **None of the above**

Definitions

- **Parenteral/IV feeding** – Introduction of a nutritive substance into the body by means other than the intestinal tract (For example, subcutaneous, intravenous).
- **Feeding tube** – Presence of any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to,

nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.

- **Mechanically Altered Diet** – A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.
- **Therapeutic diet** – A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (For example, sodium, potassium) (ADA, 2011).

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal (For example, mechanically altered food) or that rely on alternative methods (For example, parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The individual's clinical condition may potentially benefit from the various nutritional approaches included here.

Planning for Care

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

Steps for Assessment

1. Review the medical record, if available, to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.
2. Ask the individual or caregiver if any of the listed nutritional approaches were received by the individual during the 7-day look-back period.
3. Observe the individual to determine if any of the listed nutritional approaches were received by the individual during the 7-day look-back period.

Coding Instructions

Check all that apply. If none apply, check K0510Z, None of the above.

- **K0510A,** parenteral/IV feeding
- **K0510B,** feeding tube- nasogastric or abdominal (PEG)
- **K0510C,** mechanically altered diet- require change in texture of food or liquids (For example, pureed food, thickened liquids)
- **K0510D,** therapeutic diet (For example, low salt, diabetic, low cholesterol)
- **K0510Z,** none of the above

Coding Tips

Parenteral/IV feeding—The following fluids may be included **when they are administered for nutrition or hydration:**

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
- IV fluids running at KVO (Keep Vein Open)
- IV fluids contained in IV Piggybacks

- Hypodermoclysis and subcutaneous ports in hydration therapy
- IV fluids can be coded in K0510 if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration.
- **Do <u>NOT</u> include:**
  - IV Medications—Code these in (O0100H) IV medication.
  - IV fluids used to reconstitute and/or dilute medications for IV administration. IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
  - IV fluids administered solely as flushes.
  - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.

Enteral feeding formulas:

- Should not be coded as a mechanically altered diet.
- Should only be coded as **K0510D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, For example, enteral formulas specific to individuals with diabetes.

Coding Tips for K0510D

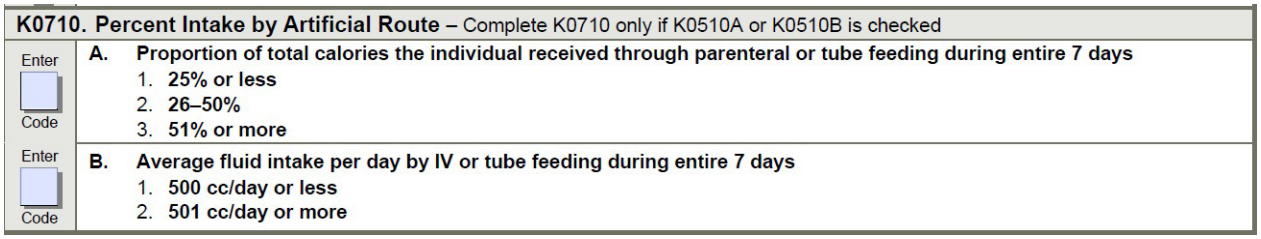
- Therapeutic diets are not defined by the content of what is provided or when it is served, but *<u>why</u>* the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be ***<u>part</u>*** of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (For example, supplement for protein-calorie malnutrition).

Example

1. Mr. J is receiving an antibiotic in 100 cc of normal saline via IV. He has a UTI, no fever, and documented adequate fluid intake. He is placed on a plan to ensure adequate hydration.
   Coding: K0510A would **NOT be checked.** The IV medication would be coded at **IV Medications** item (O0100H).
   Rationale: Although he received the fluid needed to reconstitute the antibiotic, there is no documentation to support a need for additional fluid intake.

K0710: Percent Intake by Artificial Route

Complete only if K0510A or K0510B is checked.



K0710. Percent Intake by Artificial Route – Complete K0710 only if K0510A or K0510B is checked	
Enter Code	**A. Proportion of total calories the individual received through parenteral or tube feeding during entire 7 days** 1. 25% or less 2. 26–50% 3. 51% or more
Enter Code	**B. Average fluid intake per day by IV or tube feeding during entire 7 days** 1. 500 cc/day or less 2. 501 cc/day or more

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal, such as parenteral/IV or feeding tubes, can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.

Planning for Care

- The proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration.
- Periodic reassessment is necessary to facilitate transition to increased oral intake.

K0710A, Proportion of Total Calories the Individual Received through Parental or Tube Feedings

Steps for Assessment

1. Review intake records, if available, to determine actual intake through parenteral or tube feeding routes.
2. If records are not available, talk to the individual or the caregiver to determine actual intake by mouth and through parenteral or tube feeding routes.

Coding Instructions

Calculate proportion of total calories received through parenteral or tube feeding routes.

- Select the best response:
  1. 25 percent or less
  2. 26 percent to 50 percent
  3. 51 percent or more

Example

1. **Calculation for Proportion of Total Calories from IV or Tube Feeding**: Mr. H was discharged home with a feeding tube after surgery. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past 7 days, he has been receiving tube feedings for nutritional supplementation. His calories per day are totaled as follows:

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

Coding: K0710A would be coded **3, 51 percent or more.**
Rationale: Coding aligns with the following calculation

- Total Oral intake is 2,450 calories
- Total Tube intake is 15,000 calories Total calories is 2,450 + 15,000 = 17,450 Calculation of the percentage of total calories by tube feeding: 15,000/17,450 = .859 X 100 = 85.9 percent Mr. H received 85.9 percent of his calories by tube feeding; therefore, K0710A **code 3**, **51 percent or more** is correct.

K0710B, Average Fluid Intake per Day by IV or Tube Feeding

Steps for Assessment

1. Review intake records, if available, from the last 7 days.
2. If records are not available, talk to the individual or the caregiver to determine the fluid intake.
3. Add up the total amount of fluid received each day by IV and/or tube feedings only.
4. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day.
5. Divide by 7 even if the individual did not receive IV fluids and/or tube feeding on each of the 7 days.
   Coding Instructions

Code for the average number of cc's of fluid the individual received per day by IV or tube feeding. Record what was actually received by the individual, not what was ordered.

- **Code 1:** 500 cc/day or less
- **Code 2:** 501 cc/day or more

Example

1. Calculation for Average Daily Fluid Intake: Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

Sun.	1250cc
Mon.	775cc
Tues.	925cc
Wed.	1200cc
Thurs.	1200cc
Fri.	500cc
Sat.	450cc
Total	6,300cc

Coding: K0710B would be coded **2, 501cc/day or more**.
Rationale: The total fluid intake by supplemental tube feedings = 6,300 cc. 6,300 cc divided by 7 days = 900 cc/day 900 cc is greater than 500 cc, therefore **code 2**, **501 cc/day or more** is correct.

SECTION L: ORAL/DENTAL STATUS

Intent: This item is intended to record any dental problems present in the 7-day look-back period.

L0200: Dental

L0200. Dental	
↓ Check all that apply	
☐	A. **Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
☐	B. **No natural teeth or tooth fragment(s)** (edentulous)
☐	C. **Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
☐	D. **Obvious or likely cavity or broken natural teeth**
☐	E. **Inflamed or bleeding gums or loose natural teeth**
☐	F. **Mouth or facial pain, discomfort or difficulty with chewing**
☐	G. **Unable to examine**
☐	Z. **None of the above were present**

Definitions

- **Cavity -** A tooth with a discolored hole or area of decay that has debris in it.
- **Broken Natural Teeth or Tooth Fragment -** A very large cavity, tooth broken off or decayed to gum line, or broken teeth (from a fall or trauma).
- **Oral Lesions -** A discolored area of tissue (red, white, yellow, or darkened) on the lips, gums, tongue, palate, cheek lining, or throat.
- **Oral Mass -** A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.
- **Ulcer/injury -** Mouth sore, blister or eroded area of tissue on any oral surface.

Item Rationale

Health-related Quality of Life

- Poor oral health has a negative impact on:
  - quality of life
  - overall health
  - nutritional status
- Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Planning for Care

- Assessing dental status can help identify individuals who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Steps for Assessment

1. Ask the individual about the presence of chewing problems, or mouth or facial pain/discomfort.
2. Ask the individual and/or caregiver whether the individual has or recently had dentures or partials.
3. If the individual has dentures or partials, examine for loose fit. Ask him or her to remove, and with a gloved hand, examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment.
4. Conduct exam of the individual's lips and oral cavity with dentures or partials removed, if

applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces, including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.

5. If the individual is unable to self-report, then, if possible, observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.
6. Oral examination in individuals who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these individuals.

Coding Instructions

- **Check L0200A, broken or loosely fitting full or partial denture:** if the denture or partial is chipped cracked, uncleanable, or loose. A denture is coded as loose if the individual complains that it is loose, the denture visibly moves when the individual opens his or her mouth, or the denture moves when the individual tries to talk.
- **Check L0200B, no natural teeth or tooth fragment(s) (edentulous):** if the individual is edentulous or lacks all natural teeth or parts of teeth.
- **Check L0200C, abnormal mouth tissue (ulcers/injuries, masses, oral lesions):** Select if any ulcer/injury, mass, or oral lesion is noted on any oral surface.
- **Check L0200D, obvious or likely cavity or broken natural teeth**: if any cavity or broken tooth is seen.
- **Check L0200E, inflamed or bleeding gums or loose natural teeth:** if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
- **Check L0200F, mouth or facial pain or discomfort with chewing:** if the individual reports any pain in the mouth or face, or discomfort with chewing.
- **Check L0200G, unable to examine:** if the individual's mouth cannot be examined.
- **Check L0200Z, none of the above**: if none of conditions A through F is present.

Coding Tips

- Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.

Pediatric Tips

- **Check L0200 B,** for an infant with no teeth.
- **Check L0200 F,** for a child with teething pain.
- **Check L0200 C, E, and/or F,** (all that apply) for a child with Oral Candidiasis (thrush) or stomatitis if it occurred in the 7-day look-back period.

SECTION M: SKIN CONDITIONS

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each individual's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program.

M0100: Determination of Pressure Ulcer/Injury Risk

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer/Injury Risk	
↓ Check all that apply	
☐	A. Individual has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
☐	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
☐	C. Clinical assessment
☐	Z. None of the above

Definitions

- **Pressure Ulcer/Injury Risk Factors**- Examples of risk factors include immobility and decreased functional ability, co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; impaired defuse or localized blood flow; individual's refusal of care and treatments; cognitive impairment; exposure of skin to urinary and fecal incontinence; under nutrition, malnutrition, and hydration deficits; and a healed ulcer/injury.
- **Pressure Ulcer/Injury Risk Tools-** Screening tools that are designed to help identify individuals who might develop a pressure ulcer/injury. Common risk assessment tools are the Norton Scale and the Braden Scale for Predicting Pressure Ulcer/injury Risk.

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force and friction are important contributors to pressure ulcer/injury development.
- The underlying health of an individual's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.
- Additional external factors, such as excess moisture and tissue exposure to urine or feces, can increase risk.

Planning for Care

- The plan of care should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate based on the individual's needs.
- Throughout this section, terminology referring to "healed" versus "unhealed" ulcers/injuries refers to whether or not the ulcer/injury is "closed" versus "open." When considering this, recognize that Stage 1, Suspected Deep Tissue Injury (DTI), and unstageable pressure ulcers/injuries although "closed," (That is, may be covered with tissue, eschar, slough, etc.) would not be considered "healed."

Steps for Assessment

1. Review the medical record, if available, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments.
2. Examine the individual and determine whether any ulcers/injuries, scars, or non-removable dressings/devices are present. Check key areas for pressure ulcer/injury development (For example, sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also check bony prominences (For example, elbows and ankles) and skin that is under braces or subjected to friction (For example, ears from oxygen tubing).

Coding Instructions

For this item, check all that apply:

- **Check A if individual has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device.** Review descriptions of pressure ulcers/injuries and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.
- **Check B if a formal assessment has been completed.** An example of an established pressure ulcer/injury risk tool is the Braden Scale for Predicting Pressure Sore Risk
- **Check C if the individual's risk for pressure ulcer/injury development is based on clinical assessment.** A clinical assessment could include a head-to-toe physical examination of the skin and/or observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following:
  - impaired/decreased mobility and decreased functional ability, co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; drugs, such as steroids, that may affect wound healing;
  - impaired diffuse or localized blood flow (For example, generalized atherosclerosis or lower extremity arterial insufficiency);
    - Individual's refusal of some aspects of care and treatment;
    - cognitive impairment;
    - urinary and fecal incontinence;
    - under nutrition, malnutrition, and hydration deficits; and
    - healed Stage 3 or 4 pressure ulcers/injuries, which are more likely to have recurrent breakdown.
- **Check Z if none of the above apply.**

M0150: Risk of Pressure Ulcers/Injuries

M0150. Risk of Pressure Ulcers/Injuries	
Enter Code ☐	**Is this individual at risk of developing pressure ulcers/injuries?** 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- It is important to recognize and evaluate each individual's risk factors and to identify and evaluate all areas at risk of constant pressure.

Planning for Care

- The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

Steps for Assessment

1. Based on M0100, determine if the individual is at risk for developing a pressure ulcer/injury.
2. If the medical record or clinical assessment reveals that the individual currently has a Stage 1 or greater pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the individual is at risk for worsening or new pressure ulcers/injuries.
3. Review formal risk assessment tools, if available, to determine the individual's "risk score."
4. Review components of the clinical assessment conducted for evidence of pressure ulcer/injury risk.

Coding Instructions

- **Code 0, no:** if the individual is not at risk for developing pressure ulcers/injuries based on a review of items in M0100.
- **Code 1, yes:** if the individual is at risk of developing pressure ulcers/injuries based on information gathered for M0100.

M0210: Unhealed Pressure Ulcers/Injuries

M0210. Unhealed Pressure Ulcers/Injuries	
Enter Code ☐	**Does this individual have one or more unhealed pressure ulcers/injuries?** 0. **No** → skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Definitions

- **Pressure Ulcer/Injury** – A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.
- **Healed Pressure Ulcer/Injury** - Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries and other wounds or lesions affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The pressure ulcer/injury definitions incorporate those recommended by the National Pressure Ulcer/injury Advisory Panel (NPUAP) 2016 Pressure Injury Staging System.
- An existing pressure ulcer/injury identifies individuals at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.
- Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.
- The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen.

Steps for Assessment

1. Review the medical record, if available, including skin care assessments or other skin tracking forms.
2. Examine the individual and determine whether any ulcers/injuries are present.
    - Key areas for pressure ulcer/injury development include sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess friction, are also at risk for pressure ulcers/injuries.
    - Without a full body skin assessment, a pressure ulcer/injury can be missed.
3. Examine the individual in a well-lit room. Adequate lighting is important for detecting skin changes.
4. For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage.
5. Identify any known or likely unstageable pressure ulcers/injuries.

Coding Instructions

Code based on the presence of any pressure ulcer/injury/injury (regardless of stage) in the past 7 days.

- **Code 0, no:** if the individual did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, **Number of Venous and Arterial Ulcers.**
- **Code 1, yes:** if the individual had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**.

Coding Tips

- If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury.
- Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue.
- Mucosal pressure ulcers are not staged using the skin pressure ulcer/injury/injury staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here.
- If a pressure ulcer is surgically repaired with a flap or graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.
- If an individual with diabetes mellitus (DM) has a heel ulcer/injury from pressure and the

ulcer/injury is present in the 7-day look-back period, **code 1** and proceed to code in M0300 as appropriate for the pressure ulcer/injury.

- If an individual with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal and the ulcer is present in the 7-day look-back period, **code 0** and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the ulcer when it is in this location.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have home health staff who are trained in wound assessment and who are able to distinguish scabs from eschar
- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.
- If an individual had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment.

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer/injury/injury, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

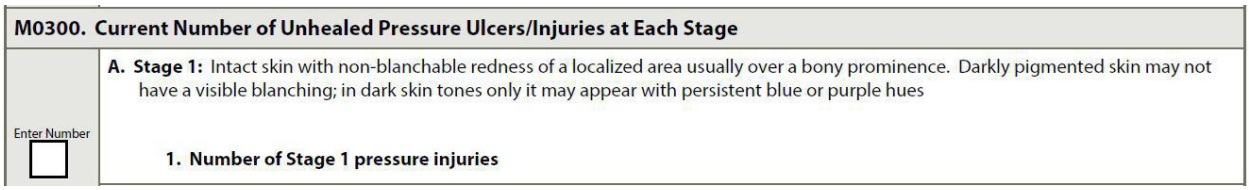
1. Observe the base of any pressure ulcers present to determine the depth of tissue layers involved.
2. Ulcer/Injury staging should be based on the ulcer's deepest visible anatomical level. Review the history of each pressure ulcer in the medical record, if available. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage.
3. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (For example, muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.
4. Clinical standards do not support reverse staging or backstaging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.

3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at https://npiap.com/general/custom.asp?page=PressureInjuryStages
4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
5. A pressure injury with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure injury. It should be coded as unstageable, as illustrated at https://woundeducators.com/wp-content/uploads/2017/09/Deep-Tissue-Pressure-Injury-April-2016.jpg
6. Known pressure ulcers/injuries covered by a non-removable dressing/device (For example, primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.
7. Known pressure ulcers/injuries covered by a non-removable dressing/device (For example, primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.

M0300A: Stage 1 Pressure Ulcers/Injuries



M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number ☐	**A. 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 **1. Number of Stage 1 pressure injuries**

Definitions

- **Stage 1 pressure ulcer/injury**- An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameter: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer/injury may appear with persistent red, blue or purple hues.
- **Non-Blanchable**- Reddened areas of tissue that do not turn white or pale when firmly pressed with a finger.

Item Rationale

Health-related Quality of Care

- Stage 1 pressure injuries may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage.

Planning for Care

- Development of a Stage 1 pressure injury should be one of multiple factors that initiate pressure ulcer/injury prevention interventions.

Steps for Assessment

1 Identify all Stage 1 pressure ulcers/injuries that are currently present.

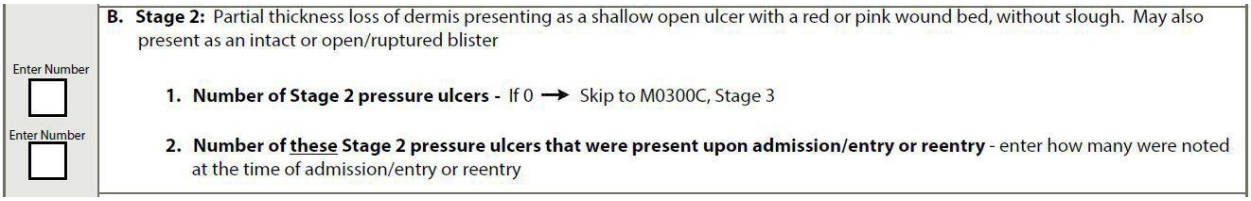
Coding Instructions for M0300A

- **Enter the number** of Stage 1 pressure ulcers/injuries that are currently present.
- **Enter 0** if no Stage 1 pressure ulcers/injuries are present.

Coding Tips

Pressure ulcers/injuries with suspected deep tissue injury should **not** be coded as Stage 1 pressure ulcers/injuries. They should be coded as unstageable pressure ulcers/injuries due to suspected deep tissue injury as **Unstageable - Deep tissue** item (M0300G).

M0300B: Stage 2 Pressure Ulcers



Definitions

- **Stage 2 Pressure Ulcer/Injury-** Partial thickness loss of dermis presenting as a shallow open ulcer/injury with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.

Item Rationale

Health-related Quality of Life

- Stage 2 pressure ulcers/injuries may worsen without proper interventions.
- These individuals are at risk for further complications or skin injury.

Planning for Care

- Most Stage 2 pressure ulcers/injuries should heal in a reasonable time frame (For example, 60 days).
- Stage 2 pressure ulcers/injuries are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers/injuries may be more likely to heal with treatment than a higher stage pressure ulcer/injury.
- The plan of care should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

Steps for Assessment

Identify all Stage 2 pressure ulcers/injuries that are currently present.

Coding Instructions for M0300B

- **Enter the number** of pressure ulcers/injuries that are currently present and whose deepest anatomical stage is Stage 2.
- **Enter 0** if no Stage 2 pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300C).

Coding Tip

- Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.
- Do not code skin tears, tape burns, moisture associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.

M0300C: Stage 3 Pressure Ulcers/Injuries

Enter Number	
☐	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 1. **Number of Stage 3 pressure ulcers**

Definition

- **Stage 3 Pressure Ulcer/Injury**- 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 or tunneling.

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers/injuries at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or caregiver intensive.
- An existing pressure ulcer/injury may put individuals at risk for further complications or skin injury. The nurse assessor should communicate findings with the individual's physician.
- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration

Steps for Assessment

- Identify all Stage 3 pressure ulcers/injuries currently present.

Coding Instructions for M0300C

- **Enter the number** of pressure ulcers/injuries that are currently present and whose deepest anatomical stage is Stage 3. **Enter 0** if no Stage 3 pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressures Ulcers/Injuries at Each Stage** item (M0300D).

Coding Tips

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure

ulcers/injuries can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.

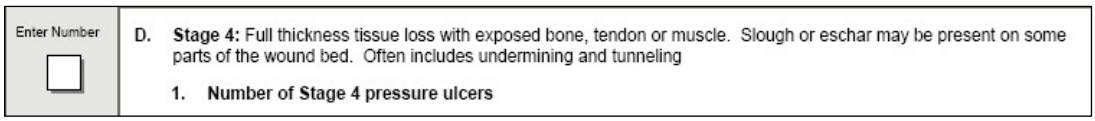
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers/injuries.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer/injury.

Example

1. Ms. T develops a Stage 2 pressure ulcer/injury. She is hospitalized due to pneumonia for 8 days and returns home with a Stage 3 pressure ulcer/injury in the same location.

   Coding: The pressure ulcer/injury/injury would be coded as **Stage 3**.
   Rationale: Even though she had a pressure ulcer/injury in the same anatomical location prior to hospitalization, because it worsened to a Stage 3 during hospitalization it should be coded as a Stage 3.

M0300D: Stage 4 Pressure Ulcers/Injuries



Definitions

- **Stage 4 Pressure Ulcer//Injury**- 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.
- **Tunneling-** A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.
- **Undermining-** The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer/injury is larger at its based than at the skin surface.

Item Rationale

Health-related Quality of Life

- Pressure ulcer/injury affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers/injuries at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventive care.
- An existing pressure ulcer/injury may put individuals at risk for further complications or skin injury. The nurse assessor should communicate findings with the individual's physician.

Steps for Assessment

- Identify all Stage 4 pressure ulcers/injuries currently present.

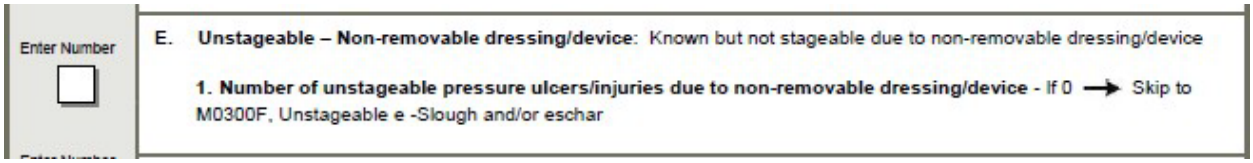
Coding Instructions for M0300D

- **Enter the number** of pressure ulcers/injuries that are currently present and whose deepest anatomical stage is Stage 4.
- **Enter 0** if no Stage 4 pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300E).

Coding Tips

- The depth of a Stage 4 pressure ulcer/injury varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers/injuries can be shallow.
- Stage 4 pressure ulcers/injuries can extend into muscle and/or supporting structures (For example, fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

M0300E: Unstageable Pressure Ulcers/Injuries Due to Non-removable Dressing/Device



Definition

- **Non-removable dressing/device**- Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for individuals because it may limit activity and may be painful**.**

Planning for Care

- Although the pressure ulcer/injury itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the individual is monitored for adequate pain control.

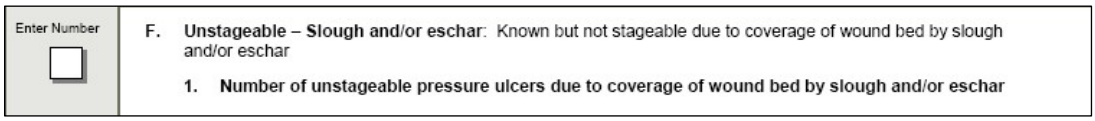
Steps for Assessment

1. Review the medical record, if available, for documentation of a pressure ulcer/injury covered by a non-removable dressing.
2. Determine the number of documented pressure ulcer/injuries covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.

Coding Instructions for M0300E

- **Enter the number** of pressure ulcers/injuries that are unstageable due to non-removable dressing/device.
- **Enter 0** if no unstageable pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300F).

M0300F: Unstageable Pressure Ulcers Due to Slough and/or Eschar



Definitions

- **Slough tissue**- Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
- **Eschar tissue**- Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.
- **Fluctuance**- Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for individuals because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Visualization of the wound bed is necessary for accurate staging.
- The presence of pressure ulcers/injuries and other skin changes should be accounted for in the interdisciplinary care plan.
- Pressure ulcers/injuries that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrosis and dead tissue and restaging once the necrotic tissue is removed.

Steps for Assessment

- Determine the number of pressure ulcers/injuries that are unstageable due to slough/eschar.

Coding Instructions for M0300F

- **Enter the number** of pressure ulcers/injuries that are unstageable due to slough and/or eschar.
- **Enter 0** if no unstageable pressure ulcers/injuries are present and skip to M0300G, Unstageable – Deep tissue injury.

Coding Tips

- Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- Stable eschar (That is, dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the individual's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

Example

1. Mr. Z has a sacral pressure ulcer/injury that is 100 percent covered with black necrotic eschar.

   Coding: The pressure ulcer/injury would be **coded as unstageable** on **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300F1).
   Rationale: The pressure ulcer/injury stage is not observable because it is covered with eschar.

M0300G: Unstageable Pressure Injuries Due to Suspected Deep Tissue Injury



Definition

- **Suspected deep injury tissue**- Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer/injury even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing an individual's ability to avoid, as well as recover from, pressure (as well as all) wounds/injuries. Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative

Planning for Care

- Deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

Steps for Assessment

- Determine the number of pressure ulcers/injuries that are unstageable due to suspected deep tissue injury.

Coding Instructions for M0300G

- **Enter the number** of unstageable pressure ulcers/injuries related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury.
- **Enter 0** if no unstageable pressure ulcers/injuries are present and skip to **M1030, Number of Venous and Arterial Ulcers.**

Coding Tips

- Once suspected deep tissue injury has opened to an ulcer/injury, reclassify the ulcer/injury into the appropriate stage. Then code the ulcer/injury for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here.

M1030: Number of Venous and Arterial Ulcers

M1030. Number of Venous and Arterial Ulcers	
Enter Number ☐	Enter the total number of venous and arterial ulcers present

Definitions

- **Venous Ulcers-** Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.
- **Arterial Ulcers-** Ulcers caused by peripheral artery disease, which commonly occur on the tips of toes, top of the foot or distal to the medial malleolus.

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The presence of venous and arterial ulcer/injury should be accounted for in the plan of care.
- This information identifies individuals at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, if available, including skin care flow sheet or other skin tracking form.
2. Examine the individual and determine whether any venous or arterial ulcer/injurys are present.

- Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (For example, above the inner and outer ankle area).
- Key areas for arterial ulcer development include the distal part of the foot, dorsum or top of the foot, or tips of the toes.
- Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (For example, bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.
- Arterial ulcers are often painful and have a pale pink wound bed, minimal exudate, minimal bleeding, and necrotic tissue.

Coding Instructions

Check all that apply in the last 7 days. Pressure ulcer/injuries coded in M0210 through M0300 should NOT be coded here.

- Enter the number of venous and arterial ulcers present.
- Enter 0: if there were no venous or arterial ulcers present.

Coding Tips

Arterial Ulcers

- Trophic skin changes (For example, dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on the wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer/injury. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on the wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer/injury.

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

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 on any part of the body.
- **Open Lesions Other Than Ulcers, Rashes, Cuts** - Most typically skin lesions 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.

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for individuals 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 the nurse will assess and evaluate.
- The presence of wounds/skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies individuals at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, if available, including skin care flow sheets or other skin tracking forms.
    - 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 ulcer/injuries coded in M0210 through M0300 should NOT be coded here.

- **M1040A,** infection of the foot (For example, cellulitis, purulent drainage)
- **M1040B,** diabetic foot ulcers
- **M1040C,** other open lesion(s) on the foot (For example, cuts, fissures)
- **M1040D,** open lesion(s) other than ulcers, rashes, cuts (For example, bullous pemphigoid)
- **M1040E,** surgical wound(s). This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- **M1040F,** burn(s)(second or third degree)

- **M1040G,** skin tear(s)
- **M1040H,** Moisture Associated Skin Damage (MASD) (For example, incontinence-associated dermatitis ([IAD], perspiration, drainage)
- **M1040Z,** none of the above were present

Coding Tips

M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the individual may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his/her feet.
- Do NOT include pressure ulcer/injuries that occur on individuals with diabetes mellitus here. For example, an ulcer/injury caused by pressure on the heel of an individual with diabetes is a pressure ulcer/injury and not a diabetic foot ulcer/injury.

M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MN/LOC, such as wounds, boils, cysts, and vesicles, should be coded in this item.
- Do NOT code rashes, abrasions, or cuts/lacerations here.
- Do NOT code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MN/LOC.

M1040E Surgical Wounds

- This category does not include healed surgical sites and stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (For example, excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1040F Burns (Second or Third Degree)

- Do NOT include first degree burns (changes in skin color only).

M1040G Skin Tears

- Skin tears are a result of shearing, friction, or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.

M1040H Moisture Associated Skin Damage (MASD)

- MASD is also referred to as maceration and includes incontinence-associated dermatitis, intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis.
- Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.
- MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present.
- MASD with skin erosion has superficial/partial thickness skin loss and may have hyper or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present. Necrosis is not found in MASD.
- If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.
- If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.

Examples

1. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening.

   Coding: Check **M1040H**, Moisture Associated Skin Damage (MASD).
   Rationale: Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis.

2. Mr. L with diabetes mellitus presents with an ulcer/injury on the heel that is due to pressure.

   Coding: This item is not checked at (M1040B). This ulcer should be coded where appropriate under Pressure Ulcer items (M0210-M0300).
   Rationale: Persons with diabetes can still develop pressure ulcers.

3. Mrs. J was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her.

   Coding: Check M1040G, Skin Tear(s).
   Rationale: Mrs. J sustained a skin tear while reaching for a magazine.

M1200: Skin and Ulcer/Injury Treatments

M1200. Skin and Ulcer/Injury Treatments	
↓ Check all that apply	
☐	A. **Pressure reducing device for chair**
☐	B. **Pressure reducing device for bed**
☐	C. **Turning/repositioning program**
☐	D. **Nutrition or hydration intervention** to manage skin problems
☐	E. **Pressure ulcer/injury care**
☐	F. **Surgical wound care**
☐	G. **Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	H. **Applications of ointments/medications** other than to feet
☐	I. **Application of dressings to feet** (with or without topical medications)
☐	Z. **None of the above** were provided

Definitions

- **Pressure Reducing Device(s)** - Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, gel or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating.
- **Turning/Repositioning Program** - Includes a consistent program for changing the individual's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the individual's needs.
- **Nutrition or Hydration Intervention to Manage Skin Problems** - Dietary measures received by the individual for the purpose of preventing or treating specific skin conditions, **For example**, wheat- free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.

Item Rationale

Health-related Quality of Life

- Appropriate prevention and treatment of skin changes and ulcer/injuries reduce complications and promotes healing.

Planning for Care

- These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the plan of care.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

Steps for Assessment

1. Review the medical record, if available, for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for individuals, so check the provider's policies and procedures, if available, and indicate here if administered during the look-back period.

2. Some skin treatments can be determined by observation. For example, observation of the individual's wheelchair and bed will reveal if the individual is using pressure-reducing devices for the bed or wheelchair.

Coding Instructions

Check all that apply in the last 7 days. ***Check Z, None of the above were provided,*** *if none applied in the past 7 days.*

- **M1200A,** pressure reducing device for chair
- **M1200B,** pressure reducing device for bed
- **M1200C,** turning/repositioning program
- **M1200D,** nutrition or hydration intervention to manage skin problems
- **M1200E,** pressure ulcer/injury care
- **M1200F,** surgical wound care
- **M1200G,** application of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids
- **M1200H,** application of ointments/medications other than to feet
- **M1200I,** application of dressings to feet (with or without topical medications)
- **M1200Z,** none of the above were provided

Coding Tips

M1200A Pressure Reducing Device

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing device should be selected based on the individualized needs of the individual.
- Do NOT include egg crate cushions of any type in this category.
- Do NOT include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the individual's position and realigning the body. The program should specify the intervention (For example, reposition on side, pillows between knees) and frequency (For example, every 2 hours).
- Progress notes, assessments, other documentation, and caregiver reports should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the individual's diet and determine if the individual is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

M1200E Pressure Ulcer/Injury Care

- Pressure ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (M0300A–G). Examples may include the use of topical dressings; enzymatic, mechanical or surgical debridement; wound irrigations; negative pressure wound therapy (NPWT); and/or hydrotherapy.

M1200F Surgical Wound Care

- Do not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer/injury continues to be coded as a pressure ulcer/injury.
- Surgical would care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (For example, excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200 G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do NOT code application of non-surgical dressings for pressure ulcer/injury(s) other than to the feet in this item; use Pressure ulcer/injury care item (M1200E).
- Dressings do not have to be applied daily to be coded on the assessment. If any dressing meeting the assessment definitions were applied even once during the 7-day look- back period, the assessor should check that item.
- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (For example Band-Aids, wound closure strips).

M1200H Application of Ointments/Medications Other than to Feet

- Do NOT code application of ointments/medications (For example, chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure ulcer/injury care.
- This category may include ointments or medications used to treat a skin condition (For example, cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (For example, nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer/injury other than a pressure ulcer/injury.
- Do not code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure

ulcer/injury care.

- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Example

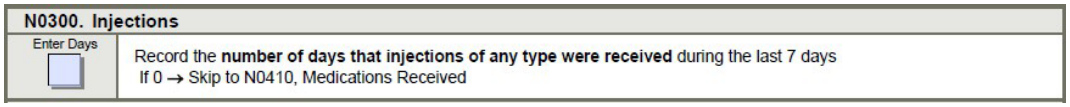
1. Mrs. G has a diabetic foot ulcer/injury on the right foot, during the past 7 days has had an Unna boot applied once (orders are to reapply the Unna boot dressing every 3 days), and has a pressure reducing mattress and pad for her wheelchair.

   Coding: Skin and Ulcer/injury Treatments items (M1200A, M1200B, and M1200I) **would all be checked.**
   Rationale: Treatments include pressure reducing mattress and pad in the wheelchair and application of the Unna boot dressing.

SECTION N: MEDICATIONS

Intent: The intent of the items in this section is to record the number of days, during the last 7 days that any type of injection (subcutaneous, intramuscular or intradermal), insulin, or oral medications were received (That is, administered or taken) by the individual.

N0300: Injections



Item Rationale

Health-related Quality of Life

- Frequency of administration of medication via injection can be an indication of stability of an individual's health status and/or complexity of care needs.

Planning for Care

- Monitor for adverse effects of injected medications.
- Although antigens and vaccines are not considered to be medications per se, it is important to track when they are given to monitor for localized or systemic reactions.

Steps for Assessment

1. Review the individual's medication administration records, if available, for the 7-day look-back period.
2. Review documentation, if available, from other health care locations where the individual may have received injections (For example, flu vaccine in a physician's office).
3. Determine if any medications were received by the individual via injection. If received, determine the number of days during the look-back period they were received.

Coding Instructions

Record the number of days during the 7-day look-back period that the individual received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection.

Insulin injections are counted in this item as well as in Item N0350.

- Count the number of days that the individual received any type of injection (subcutaneous, intramuscular or intradermal).
- Record the number of days that any type of injection (subcutaneous, intramuscular or intradermal) was received in Item N0300.

Coding Tips and Special Populations

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

- If two injections were administered on the same day, the number of days the individual received injections would be coded 1 day.
- Do not code Baclofen, epidural and intrathecal pumps here; they are coded under IV medications in O0100H.

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: He received injections on 3 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: She received injections on 1 day during the 7-day look-back period.

N0350: Insulin

N0350. Insulin	
Enter Days ☐	A. Insulin injections – Record the number of days that insulin injections were received during the last 7 days
Enter Days ☐	B. Orders for insulin – Record the number of days the physician (or authorized assistant or practitioner) changed the individual's insulin orders during the last 7 days

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Orders for insulin may have to change depending on the individual's condition (For example, fever or other illness) and/or laboratory results.
- Ensure that dosage and time of injections take into account meals, activity, etc., based on an individualized assessment.
- Monitor for adverse effects of insulin injections (For example, hypoglycemia).
- Monitor HbA1c and blood glucose levels to ensure appropriate amounts of insulin are being administered.

Steps for Assessment

1. Review the individual's medication administration records, if available, for the 7-day look- back period.
2. Determine if the individual received insulin injections during the look-back period.

3. Determine if the individual's insulin orders were changed during the look-back period.
4. Count the number of days that insulin injections were received and/or changed.

Coding Instructions for N0350A

- Enter in Item N0350A, the number of days during the look-back period that insulin injections were received.

Coding Instructions for N0350B

- Enter in Item N0350B, the number of days that the individual's insulin orders were changed during the look-back period.

Coding Tips and Special Populations

- A sliding scale dosage schedule that is written to cover different dosages depending on lab values does not count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- If the sliding scale order is new, discontinued, or is the first sliding scale order for the individual, these days can be counted and coded.

N0410: Medications Received

N0410. Medications Received	
↓ **Indicate the number of DAYS the individual received the following medications by pharmacological classification, not how it is used, during the last 7 days.** Enter "0" if medication was not received by the individual during the last 7 days.	
Enter Days ☐	**A. Antipsychotic**
Enter Days ☐	**B. Antianxiety**
Enter Days ☐	**C. Antidepressant**
Enter Days ☐	**D. Hypnotic**
Enter Days ☐	**E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days ☐	**F. Antibiotic**
Enter Days ☐	**G. Diuretic**
Enter Days ☐	**H. Opioid**

Definitions

- **Adverse Consequence -** An unpleasant symptom or event that is caused by or associated with a medication, impairment or decline in an individual's physical condition, mental, functional or psychosocial status. It may include various types of adverse drug reactions (ADR) and interactions (For example, medication-medication, medication-food, and medication-disease).
- **Non-Pharmacological Intervention -** Approaches that do not involve the use of medication to address a medical condition.
- **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 data 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, discontinuing, or continuing any interventions.
- **Sleep Hygiene-** Practices, habits and environmental factors that promote and/or improve sleep patterns.
- **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.

Item Rationale

Health-related Quality of Life

- Medications are an integral part of the care provided to individuals. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.
- Individuals taking medications in these drug classes are at risk of side effects that can adversely affect health, safety, and quality of life.
- While assuring that only those medications required to treat the individual's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the individual's assessed condition.
- As part of all medication management, it is important to consider non-pharmacological approaches. Educating community caregivers and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications.

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 individual'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 the individual. Progress toward meeting the goals should be evaluated routinely.
- Educate caregivers to be observant for adverse effects.
- Implement systematic monitoring of each individual taking any of these medications to identify adverse consequences early.

Steps for Assessment

1. Review the individual's medical record or medication administration record, if available, for documentation that any of these medications were received by the individual during the 7- day look-back period.
2. Review documentation from other health care settings where the individual may have received any of these medications (For example, valium given in the emergency room).
3. Ask the individual or caregiver what medications the individual has taken during the 7-day look-back period.

Coding Instructions

- **Check A, antipsychotic:** if antipsychotic medication was received by the individual at any time during the 7-day look-back period.
- **Check B, antianxiety:** if anxiolytic medication was received by the individual at any time during the 7-day look-back period.
- **Check C, antidepressant:** if antidepressant medication was received by the individual at any time during the 7-day look-back period.
- **Check D, hypnotic:** if hypnotic medication was received by the individual at any time during the 7-day look-back period.
- **Check E, anticoagulant (For example, warfarin, heparin, or low- molecular weight heparin):** if anticoagulant medication was received by the individual at any time during the 7-day look- back period. Do not code antiplatelet medications such as aspirin /extended release, dipyridamole (Aggrenox), or clopidogrel (Plavix) here.
- **Check F, antibiotic:** if antibiotics were received by the individual at any time during the 7- day look-back period.
- **Check G, diuretic:** if diuretics were received by the individual at any time during the 7-day look-back period.
- **Check H, Opioid:** if opioids were received by the individual at any time during the 7-day look-back period.
- **Check Z, none of the above were received:** if none of the medications in Item N0410 were received during the 7-day look-back period (or since the Initial Assessment if less than 7 days).

Coding Tips and Special Populations

- Code medications according to a drug's pharmacological classification, not how it is used. For example, Oxazepan (Serax) may be used as a hypnotic, but it is classified as an antianxiety medication. It would be coded as an antianxiety medication.
- Include any of these medications given by any route (For example, PO, IM, or IV) in any setting.
- Code a medication even if it was given only once during the look-back period.
- Count long-acting medications, such as fluphenazine deconoate (Prolixin) or haloperidol deconoate (Haldol), that are given every few weeks or monthly **only** if they are given during the 7-day look-back period.
- Combination medications should be coded in all categories that constitute the combination. For example, if the individual receives a single tablet that combines an antipsychotic and an antidepressant, then both antipsychotic and antidepressant should be coded.

- Over-the-counter sleeping medications are not coded as hypnotics, as they are not classified as hypnotic drugs.
- When individuals are having difficulty sleeping, caregivers should explore non- pharmacological interventions (For example, sleep hygiene approaches that individualize the sleep and wake times to accommodate the person's wishes and prior customary routine) to try to improve sleep prior to initiating pharmacologic interventions. If individuals are currently on sleep-enhancing medications, caregivers can try non-pharmacologic interventions to help reduce the need for these medications or eliminate them.
- Many psychoactive medications increase confusion, sedation, and falls. For those individuals who are already at risk for these conditions, a plan of care should be created to 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 psychopharmacologic drugs 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 individual'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.
- Prior to discontinuing a psychoactive drug, individuals may need a GDR or tapering to avoid withdrawal syndrome (For example, selective serotonin reuptake inhibitors [SRIs], tricyclic antidepressants [TCAs]).
- Individuals who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances, duration of use, and stability of monitoring results (For example, Prothrombin Time [PT]/International Normalization Ratio [INR]).
- Multiple medication interactions exist with use of anticoagulants which may significantly increase PT/INR results to levels associated with life-threatening bleeding, or decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (For example, the composition varies among manufacturers). Therefore, they should not be counted as medications (For example, chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document an individual's intake of herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the individual is currently taking.

- Opioid medications can be an effective intervention in an individual's pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root- cause analysis of the individual's pain should be conducted prior to initiation of an opioid medication and re-evaluation of the individual's pain, side effects, and medication use and plan should be ongoing.

Example

1. Mrs. P. received the following medications:
    - Haloperidol (Haldol) 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday
    - Lorazepam (Ativan) 1 mg PO QAM: Received every day.
    - Temazepam (Restoril) 15 mg PO QHS PRN: Received at HS on Tuesday and Wednesday only.

    Coding: The following **Medications** item (N0410), would be checked: **A, antipsychotic; B, antianxiety;** and **D, hypnotic.**
    Rationale: Haloperidol is an antipsychotic drug, Lorazepam is an antianxiety drug, and Temazepam is a hypnotic drug.

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, programs, and procedures that the individual received during the specified time periods.

O0100: Special Treatments, Procedures, and Programs

(14-Day Look-back)

Section O	Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed during the last 14 days	Check all that apply ↓
Cancer Treatments	
A. Chemotherapy	☐
B. Radiation	☐
Respiratory Treatments	
C. Oxygen therapy	☐
D. Suctioning	☐
E. Tracheostomy care	☐
F. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	☐
Other	
H. IV medications	☐
I. Transfusions	☐
J. Dialysis	☐
K. Hospice care	☐
L. Respite care	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐
N99. Psychiatric care	☐
None of the Above	
Z. None of the above	☐

Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedures, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

Item Rationale

Health-related Quality of Life

- The treatments, programs, and procedures listed Section Ocan have a profound effect on an individual's health status, self-image, dignity, and quality of life.

Planning for Care

- Reevaluation of special treatments the individual received or programs that the individual was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments or program.

Steps for Assessment

1. Review the individual's medical record, if available, to determine whether or not the individual received any of the special treatments, programs, or procedures within the last 14 days.

Coding Instructions

Check all treatments, programs, and procedures received by the individual within the 14-day look-back period. ***Check Z, None of the above.***

- **O0100A, Chemotherapy**
  Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, Megace (megestrol acetate) is classified in the **Physician's Desk Reference (PDR**) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the individual is not receiving the Megace for chemotherapy purposes in this situation. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding this assessment. IV's, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), and O0100I (Transfusions).

    - Example: Ms. J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After her cancer treatment, Ms. J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

- **O0100B, Radiation**
  Code intermittent radiation therapy, as well as, radiation administered via radiation implant in this item.

- **O0100C, Oxygen therapy**
  Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to an individual to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the individual places or removes his/her own oxygen mask, cannula.

- **O0100D, Suctioning**
  Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the individual performs his/her own tracheal and/or nasopharyngeal suctioning.

- **O0100E, Tracheostomy care**
  Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the individual performs his/her own tracheostomy care.

- **O0100F, Invasive Mechanical Ventilator (ventilator or respirator)**
  Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensures adequate ventilation in the individual who is, or who may become, (such as

during weaning attempts) **unable to support his or her own respiration** in this item. During invasive mechanical ventilation the individual's breathing is controlled by the ventilator. Individuals receiving closed-system ventilation include those individuals receiving ventilation via an endotracheal tube (For example, nasally or orally intubated) or tracheostomy. An individual who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

  - Example: Mrs. J is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day, because of an irreversible neurological injury and inability to breathe on her own. O0100F should be checked, as Mrs. J is using an invasive mechanical ventilator because she is unable to initiate spontaneous breathing on her own and the ventilator is controlling her breathing.

- **O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP)**
  Code any type of CPAP or BiPAP respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support his or her own spontaneous respiration** by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that "breathe" for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the individual places or removes his/her own BiPAP/CPAP mask/device.

  - Example: Mr. M has sleep apnea and requires a CPAP device to be worn when sleeping. The caregiver may set-up the water receptacle and humidifier element of the machine. Mr. M puts on the CPAP mask and starts the machine prior to falling asleep. O0100G should be checked as Mr. M is able to breathe on his own and wears the CPAP mask when he is sleeping to manage his sleep apnea.

- **O0100H, IV medications**
  Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here. To determine what products are considered medications or for more information consult the FDA website:

  - The Orange Book, http://www.accessdata.fda.gov/scripts/cder/ob/
  - The National Drug Code Directory, http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

- **O0100I, Transfusions**
  Code transfusions of blood or any blood products (For example, platelets, synthetic blood products), which are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **O0100J, Dialysis**
  Code peritoneal or renal dialysis that occurs in the community setting (For example, outpatient setting or in an individual's residence) in this item. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous

Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0500A (Parenteral/IV), O0100H (IV medications), and O0100I (transfusions). This item may be coded if the individual performs his/her own dialysis.

- **O0100K, Hospice care**
  Code individuals identified as being in a hospice program for terminally ill persons where an array of services is provided 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.

- **O0100L, Respite care**
  Code only when the individual has utilized respite care for the purpose of providing relief to the individual's primary home-based caregiver(s) in this item. This item includes in-home and out- of-home respite.

- **O0100M, Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)**

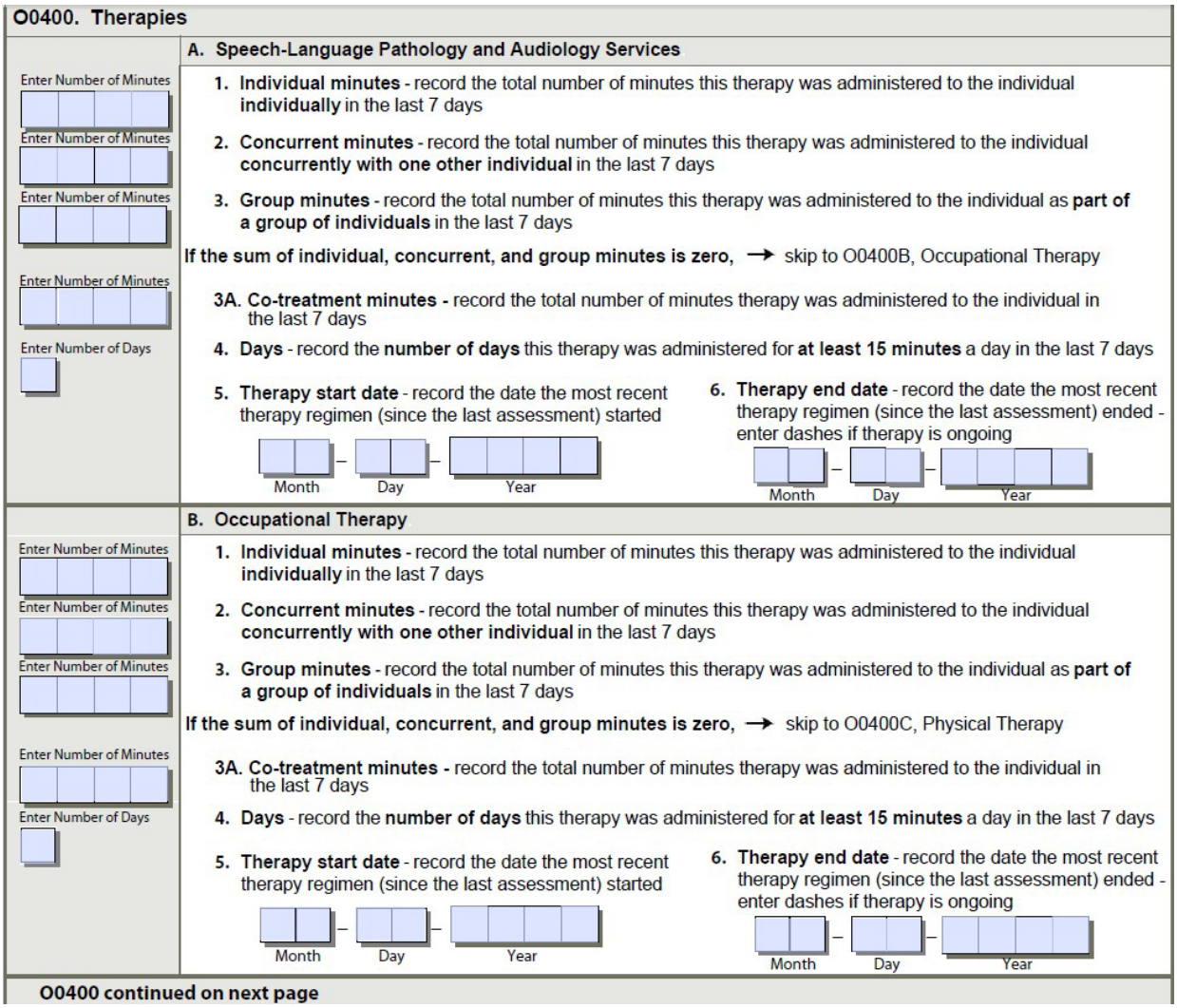
  Code only when the individual requires strict isolation or quarantine in a separate room because of active infection (That is, symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease, in an attempt to prevent spread of illness. Do not code this item if the individual only has a **history** of infectious disease (For example, MRSA or C-Diff with no active symptoms). Do not code this item if the "isolation" primarily consists of body/fluid precautions, because these types of precautions apply to everyone. Transmission-Based Precautions must also be considered regarding the type and clinical presentation related to the specific communicable disease. The three types of transmission-based precautions are contact, droplet, and airborne.
  More information related to the types of transmission-based precautions can be found in the **2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings** https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf

- **O0100N99, Psychiatric Care**
  Psychiatric Care is therapy provided only by a licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a Masters degree and/or certification from the American Nurses Association. Psychiatric Technicians are not considered to be licensed mental health professionals and their services may not be counted in this item. If the State does not license a certain category of professionals working in your community program, you may not count the services of those unlicensed therapists in this item.

  - Code only if the individual has received services through a licensed mental health professional within the last 14 days.

- **O0100Z, None of the above**
  Code if none of the above treatments, programs, or procedures were received.

O0400: Therapies



O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the individual **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the individual **concurrently with one other individual** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

Enter Number of Minutes

3A. **Co-treatment minutes** - record the total number of minutes therapy was administered to the individual in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the last assessment) started

Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing

Month – Day – Year

B. Occupational Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the individual **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the individual **concurrently with one other individual** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

Enter Number of Minutes

3A. **Co-treatment minutes** - record the total number of minutes therapy was administered to the individual in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

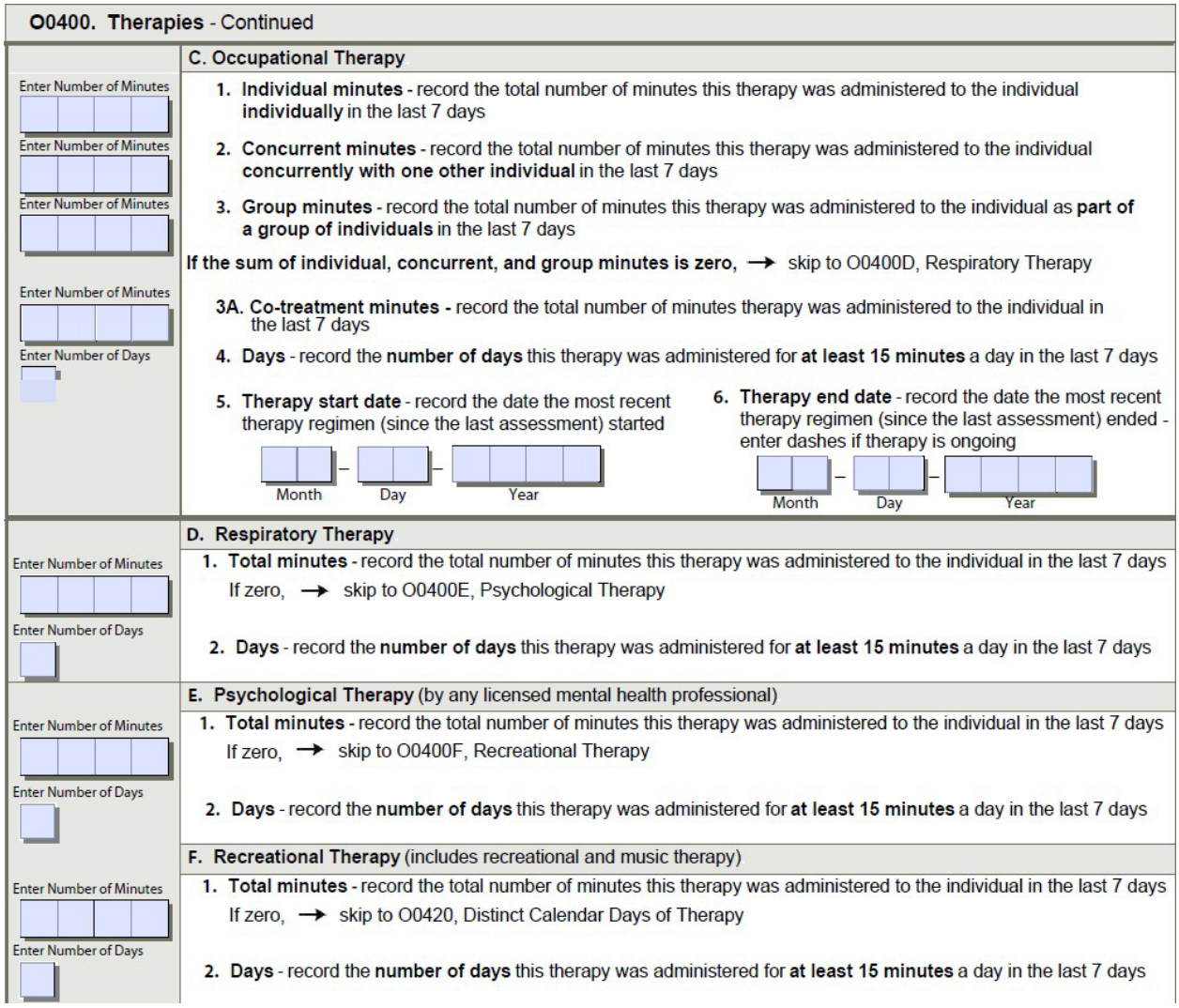
5. **Therapy start date** - record the date the most recent therapy regimen (since the last assessment) started

Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing

Month – Day – Year

O0400 continued on next page



Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician or licensed practitioner (physician's assistant, nurse practitioner, and/or clinical nurse specialist), is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to individuals.
- Rehabilitation (That is, via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help individuals to attain or maintain their highest level of well-being and improve their quality of life.

Planning for Care

- Code only medically necessary therapies that occurred in the 7-day look-back period. All therapies listed in this section must be coded regardless of whether they occurred inside or outside the home, such as in a school or clinic setting and regardless of how the service was purchased.
- To be coded here, therapies must be:

  (1) ordered by a physician or licensed practitioner based on a qualified therapist's assessment

(That is, one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan,

(2) performed by a qualified therapist (That is, one who meets State credentialing requirements) with one exception; respiratory therapy must be coded here if provided by a trained nurse, or if it is a task delegated to a trained caregiver under the license of a trained nurse, **Note:** Nebulizer treatments administered by family members (or other individuals, non- licensed or not delegated to under the license of a nurse) are not coded in O0400D1; in this case nebulizer treatments should be entered in section S9, Medications, and may also be noted in S10, Comments.

(3) documented in the individual's medical record, and

(4) care planned and periodically evaluated to ensure that the individual receives needed therapies and that current treatment plans are effective.

Steps for Assessment

1. Review the individual's medical record (For example, rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes) if available, and consult with each of the qualified care providers to collect the information required for this item.

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes** —Enter the total number of minutes of therapy that was provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one individual at a time.
- **Concurrent minutes** —Enter the total number of minutes of therapy that was provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 individuals at the same time, when the individuals are performing two different activities.
- **Group minutes** —Enter the total number of minutes of therapy that was provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined as the treatment of 2 to 4 individuals who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.
    - **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the individual in co-treatment sessions in the last 7 days. Enter 0 if none were provided."
- **Days** —Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more during the day. **Enter 0** if none was provided **or** if therapy was provided for less than 15 minutes on that day.
- **Therapy Start Date**—Record the date of the most recent therapy regimen (since the last assessment) started. Start dates are not affected by the 7-day look-back period.
- **Therapy End Date**—Record the date the most recent therapy regimen (since the last assessment) ended. Enter dashes if therapy is ongoing.

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none.
- **Days** —Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if none **or** if therapy was provided for less than 15 minutes in the day.

Coding Tips and Minutes of Therapy

- Includes only therapies that were provided when the individual is living/being cared for in the community setting (For example, therapies provided at the individual's residence, the school setting, a Day Activity and Health Services Program (DAHS) facility). Do **NOT** include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility.
- An exact therapy start date is not required. Ask the individual or caregiver when the therapy started, for example: 1)06-01-2009 can be entered if all the individual or caregiver can recall is the therapy started in the summer of 2009; 2)01-01-2008 can be entered if the individual or caregiver can only recall the year the therapy started.
- For individuals who receive therapy on an ongoing basis, enter the start date of the most recent therapy treatment plan. If for example: 1)the individual has been receiving physical therapy for the past year then has surgery and post-operatively the therapy changes, enter the start date of the new therapy plan; 2)the individual falls, the therapy changes and new therapy goals are established, enter the start date of the new therapy plan.
- The therapist's time spent on documentation or on initial evaluation is not included.
- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- The individual's treatment time starts when he or she begins the first treatment activity or task and ends when he or she finishes with the last apparatus or intervention/task and the treatment is ended, as long as the services were not interrupted (for example, by a bathroom break or a nontherapeutic rest).
- The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular individual, is the set-up time and may be included in the count of minutes of therapy delivered to the individual.
- Include only skilled therapy services. Skilled therapy services must meet the following conditions:
    - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the community setting that is approved by the physician after any needed consultation with the qualified therapist;
    - the services must be of a level of complexity and sophistication, or the condition of the individual must be of a nature that requires the judgment, knowledge, and skills of a therapist;
    - the services must be provided with the expectation, based on the assessment made by the physician of the individual's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;

- the services must be considered under accepted standards of medical practice to be specific and effective treatment for the individual's condition; and,
- the services must be reasonable and necessary for the treatment of the individual's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

- In the community setting concurrent and group therapies rarely occur.
- Recreational therapy is not a skilled service according to the Social Security Act. However, for purposes of the Medical Necessity/Level of Care Assessment (MN/LOC), providers should record services for recreational therapy (Item O0400F) when the following criteria are met:
  - the physician orders recreational therapy that provides therapeutic stimulation beyond the general activity in the community setting;
  - the physician's order includes a statement of frequency, duration, and scope of treatment;
  - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by a therapeutic recreation specialist;
  - the services are required and provided by a state licensed or nationally certified therapeutic recreation specialist or therapeutic recreation assistant, who is under the direction of a therapeutic recreation specialist; and
  - the services must be reasonable and necessary for the individual's condition.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the home health care organization only if he or she is under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MN/LOC.
- Record only the actual minutes of therapy. The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MN/LOC requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs, if available, may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MN/LOC assessment.

Non-Skilled Services

- Once the licensed therapist has designed a maintenance program and discharged the individual from rehabilitation (That is, skilled)illed) therapy program, the services performed by the therapist and the assistant are **not** to be reported in Item O0400A, B, or C (Therapies). The services may be reported on the MN/LOC assessment in Item O0500 (Restorative Nursing Programs), provided the requirements for restorative nursing programs are met.
- Services provided by aides are **not** skilled services.

Co-treatment

- When two clinicians, each from a different discipline, treat one individual at the same time, the clinicians must split the time between the two disciplines as they deem appropriate. They may not each count the treatment session in full, and the split times when added may not exceed the actual total amount of the treatment session.

Therapy Aides and Students

Therapy Aides

- Aides cannot provide skilled services. Only the time an aide spends on set-up for skilled services may be coded on the MN/LOC (For example, set up the treatment area for wound therapy).

Therapy Students

- Medicare Part A—Therapy students must be in line-of-sight supervision of the professional therapist (**Federal Register**, July 30, 1999). The time spent by the therapist providing skilled services by supervising the student who participates by following the therapist's direction under line-of-sight supervision may be coded on the MN/LOC.
- Medicare Part B—The following criteria must be met in order for services provided by a student to be coded on the MN/LOC. The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
    - The practitioner is not engaged in treating another patient or doing other tasks at the same time.
    - The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician's service, not for the student's services.)
    - Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist.

Modes of Therapy

An individual may receive therapy via different modes during the same day or even treatment session. The therapist and assistant must determine which mode(s) of therapy and the amount of time the individual receives for each mode.

Individual Therapy

- The treatment of one individual at a time. The individual is receiving the therapist's or the assistant's full attention. Treatment of an individual individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count. For example, the speech-language pathologist treats the individual individually during breakfast for 8 minutes and again at lunch for 13 minutes. The total of individual time for this day would be 21 minutes.

Concurrent Therapy

- **Medicare Part A**
  The treatment of 2 individuals at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.
- **Medicare Part B**
  The treatment of two or more individuals at the same time is documented as group treatment, regardless of whether those individuals are doing the same or different activities.

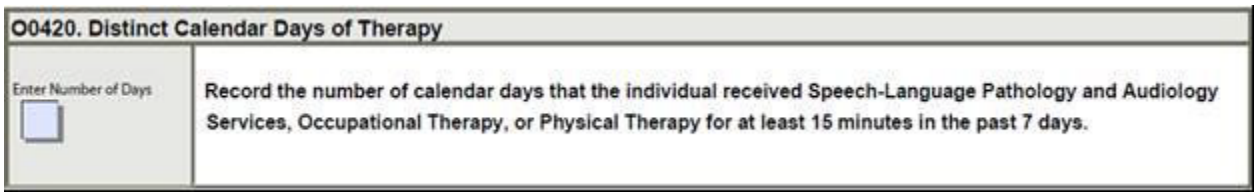
Group Therapy

- **Medicare Part A**
  The treatment of 2 to 4 individuals, regardless of payer source, who are performing similar activities, and are supervised, by a therapist or assistant who is not supervising any other individuals.
- **Medicare Part B**
  The treatment of 2 or more individuals simultaneously who may or may not be performing the same activity.

Example

Following a stay in a rehabilitation facility for a hip fracture, Mrs. F has now returned home. A licensed physical therapist from a local home health agency is providing skilled therapy for 30 minutes, twice per week. **Code 60 for this service in section O0400C1**. In addition, the therapist has instructed Mrs. F's caregiver in a home program to increase Mrs. F's walking skills/distance. **Code the home program administered by the caregiver in section O0500F**.

O0420: Distinct Calendar Days of Therapy



Item Rationale

- To record the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Coding Instructions:

Enter the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days. If an individual receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

- Example 1: Mrs. T. received 60 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mrs. T also received 45 minutes of occupational therapy on Monday, Tuesday and Friday during the 7-day look-back period. Given the therapy services received by Mrs. T during the 7-day look-back period, item O0420 would be coded as 4 because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look-back period (That is Monday, Tuesday, Wednesday, and Friday).
- Example 2: Mr. F. received 120 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mr. F also received 90 minutes of occupational therapy on Monday, Wednesday and Friday during the 7-day look-back period. Finally, Mr. F received 60 minutes of speech- language pathology services on Monday and Friday during the 7-day look-back period. Given the therapy services received by Mr. F during the 7-day look-back period, item O0420 would be coded as 3 because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look- back period (That is Monday, Wednesday, and Friday)."

O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs	
Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
☐	D. Bed mobility
☐	E. Transfer
☐	F. Walking
☐	G. Dressing and/or grooming
☐	H. Eating and/or swallowing
☐	I. Amputation/prostheses care
☐	J. Communication

Item Rationale

Health-related Quality of Life

- Maintaining independence in activities of daily living and mobility is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers/injuries.

Planning for Care

- Restorative program refers to nursing interventions that promote the individual's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
- An individual may be started on a restorative program when he or she has restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise. Generally, restorative nursing programs are initiated when an individual is discharged from formalized physical, occupational, or speech rehabilitation therapy. Persons qualified to perform rehabilitation/restorative care include, but are not limited to: family members, caregivers and attendants specifically trained in these techniques/practices. This section does not include procedures carried out by the qualified therapist as identified in section O0400.

Steps for Assessment

1. Review the restorative nursing program notes and/or flow sheets in the medical record if available.
2. For the 7-day look-back period, enter the number of days on which the technique, procedure, or activity was received and/or practiced for a total of at least 15 minutes during the 24-hour period.
3. The following criteria for restorative care must be met:
    - Measurable objectives and interventions must be documented in the plan of care. If a restorative nursing program is in place when a plan of care is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good

clinical practice would indicate that the results of this reassessment should be documented.

- Evidence of periodic evaluation by the licensed nurse must be documented. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be skilled in the techniques that promote individual involvement in the activity.
- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program.
- Restorative nursing does not require a physician's order.

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** Item (O0400A), **Occupational Therapy** item (O0400B), and **Physical Therapy** (O0400C).
- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. For example, to check **Technique—Range of Motion [Passive] i**tem (O0500A), 15 or more minutes of passive range of motion (PROM) must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (For example, 10 minutes on the day shift plus 5 minutes on the evening shift). However, 15-minute time increments cannot be obtained by combining 5 minutes of **Technique—Range of Motion [Passive]** item (O0500A), 5 minutes of **Technique—Range of Motion [Active]** item (O0500B), and 5 minutes of **Splint or Brace Assistance** item (O0500C), over 2 days in the last 7 days.
- Review for each activity throughout the 24-hour period. **Enter 0**, if none.

Technique

Activities provided by caregivers trained in restorative nursing techniques.

- **O0500A, Range of Motion (Passive)**
  Code provision of passive movements to maintain flexibility and useful motion in the joints of the body. These exercises must be planned, scheduled, and documented in the medical record.
- **O0500B, Range of Motion (Active)**
  Code exercises performed by the individual, with cueing, supervision, or physical assist by caregivers that are planned, scheduled, and documented in the medical record. Include active ROM and active-assisted ROM.
- **O0500C, Splint or Brace Assistance**
  Code provision of (1) verbal and physical guidance and direction that teaches the individual how to apply, manipulate, and care for a brace or splint, or (2) a scheduled program of applying and removing a splint or brace. These sessions are planned, scheduled, and documented in the medical record.

Training and Skill Practice

Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any caregivers under the supervision of a licensed nurse.

- **O0500D, Bed Mobility**
  Code activities provided to improve or maintain the individual's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed.
- **O0500E, Transfer**
  Code activities provided to improve or maintain the individual's self-performance in moving between surfaces or planes either with or without assistive devices.
- **O0500F, Walking**
  Code activities provided to improve or maintain the individual's self-performance in walking, with or without assistive devices.
- **O0500G, Dressing and/or Grooming**
  Code activities provided to improve or maintain the individual's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.
- **O0500H, Eating and/or Swallowing**
  Code activities provided to improve or maintain the individual's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the individual's ability to ingest nutrition and hydration by mouth.
- **O0500I, Amputation/ Prostheses Care**
  Code activities provided to improve or maintain the individual's self-performance in putting on and removing prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (For example, leg stump or eye socket). Dentures are not considered to be prostheses for coding this item.
- **O0500J, Communication**
  Code activities provided to improve or maintain the individual's self-performance in functional communication skills or assisting the individual in using residual communication skills and adaptive devices.

Coding Tips

- For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the individual's available range of motion. The individual provides no assistance.
- For range of motion (active): any participation by the individual in the ROM activity should be coded here.
- For both active and passive range of motion: movement by an individual that is incidental to dressing, bathing, etc., does not count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by caregivers specifically trained in the procedures.
- For splint or brace assistance: assess the individual's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices as nursing restorative care is coded when the following criteria are met: (1) ordered by a physician, (2) caregivers have been trained in technique (For example, properly aligning individual's limb in device, adjusting available range of motion), and (3) monitoring of the device. The caregiver should document the application of the device and the effects on the individual. Do **not** include the time the individual is receiving treatment in the device. Include only the actual time caregivers were engaged in applying and monitoring the device.

- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Grooming programs, including programs to help individuals learn to apply make-up, may be considered restorative nursing programs. These grooming programs would need to have documented goals, objectives, and documentation of progress to be coded in this section.

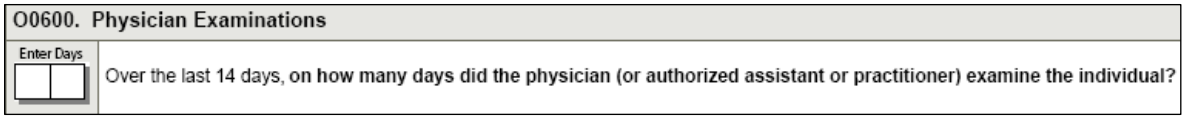
Example

1. Mrs. D. is receiving training and skill practice in walking using a quad cane. Together, Mrs. D. and her caregiver have set progressive walking distance goals. The caregiver has received instruction on how to provide Mrs. D. with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to walk with her quad cane. Each teaching and practice episode for walking takes approximately 15 minutes.

   Coding: Walking item (O0500F), would be **coded 7.**
   Rationale: Because this was the number of days that practice training for walking was provided.

O0600: Physician Examinations

(14-Day Look-back)



Item Rationale

Health-related Quality of Life

- Health status that requires frequent physician examinations can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- Frequency of physician examinations can be an indication of medical complexity and stability of the individual's health status.

Steps for Assessment

1. Review the physician progress notes, if available, for evidence of examinations by the physician/practitioner. If notes are not available, ask the individual or caregiver if an examination took place within the 14-day look-back period.

Coding Instructions

- Record the **number of days** that a physician examined the individual in the look-back period.

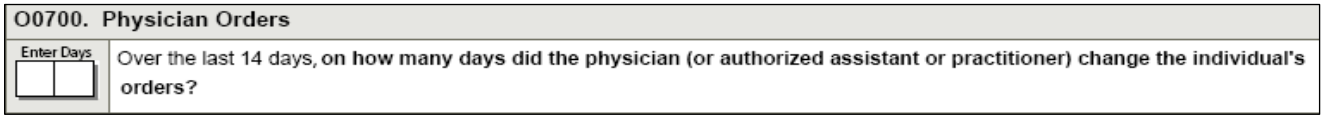
Coding Tips

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician.
- Examination (partial or full) can occur in the community setting or in the physician's office.

- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If an individual is evaluated by a physician (For example, while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the individual, monitoring the individual for response to the treatment, or adjusting the treatment as a result of the examination.
- The licensed psychological therapy by a Psychologist (PhD) should be recorded in **O0400E, Psychological Therapy**.
- Does not include visits made by Medicine Men.

O0700: Physician Orders

(14-Day Look-back)



Item Rationale

Health-related Quality of Life

- Health status that requires frequent physician (or authorized assistant or practitioner) order changes can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- Frequency of physician (or authorized assistant or practitioner) order changes can be an indication of medical complexity and stability of the individual's health status.

Steps for Assessment

1. Review the physician order sheets in the medical record, if available.
2. Determine the number of days during the 14-day look-back period that a physician (or authorized assistant or practitioner) changed the individual's orders.

Coding Instruction

- Enter the **number of days** during the 14-day look-back period in which a physician (or authorized assistant or practitioner) changed the individual's orders.

Coding Tips

- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.

- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- When an as needed (PRN) order was already on file, the potential need for the service had already been identified. Notification of the physician (or authorized assistant or practitioner) that the PRN order was activated does **not** constitute a new or changed order and may **not** be counted when coding this item.
- If an individual has multiple physicians (For example, surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MN/LOC must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (For example, for a new or altered treatment).
- Orders written to increase the individual's PDPM LTC level classification are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.

SECTION P: RESTRAINTS AND ALARMS

Intent: The intent of this section is to record the frequency that the individual was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7- day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.

Prior to using any restraint, the caregiver should assess the individual to properly identify the individual's needs and the medical symptom(s) that the restraint is being employed to address. If a restraint is needed to treat the individual's medical symptom, the caregiver is responsible for assessing the appropriateness of that restraint. When the decision is made to use a restraint, HHSC encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. The use of restraints should be the exception, not the rule.

P0100: Physical Restraints

P0100. Physical Restraints		
Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the individual's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body		
	↓ Enter Codes in Boxes	
		Used in Bed
	☐	A. Bed rail
	☐	B. Trunk restraint
	☐	C. Limb restraint
Coding: 0. Not used 1. Used less than daily 2. Used daily	☐	D. Other
		Used in Chair or Out of Bed
	☐	E. Trunk restraint
	☐	F. Limb restraint
	☐	G. Chair prevents rising
	☐	H. Other

Definitions

- **Remove easily -** means that the manual method, device, material, or equipment can be removed intentionally by the individual in the same manner as it was applied by the caregiver (For example, side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the individual's physical condition and ability to accomplish his or her objective (For example, transfer to a chair, get to the bathroom in time).
- **Freedom of movement -** means any change in place or position for the body or any part of the body that the person is physically able to control or access.

Item Rationale

Health-related Quality of Life

- Individuals who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In many cases, the risk of using the device may be greater than the risk of not using the device.
- Growing evidence supports that physical restraints have a limited role in medical care. Restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers/injuries.

- The risk of restraint-related injury and death is significant.

Planning for Care

- When the use of restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues.
- When the interdisciplinary team determines that the use of restraints is the appropriate course of action, the least restrictive device that will meet the individual's needs should be selected.

- Planning for care should focus on preventing the adverse effects of restraint use.
  Steps for Assessment
  1. Review the individual's medical record, if available, to determine if physical restraints were used during the 7-day look-back period.
  2. Ask the caregiver if physical restraints were used during the 7-day look- back period.
  3. Consult the caregiver to determine the individual's cognitive and physical status/limitations.
  4. Considering the physical restraint definition as well as the clarifications listed below, observe the individual to determine the effect the restraint has on the individual's normal function. Do not focus on the type of device, intent, or reason behind the use of the device.
  5. Evaluate whether the individual can easily and voluntarily remove the device, material, or equipment. If the individual cannot easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the individual's access to his or her own body.
  6. Determine if the device, material, or equipment meets the definition of a physical restraint as clarified below. Remember, the decision about coding any device, material, equipment, or physical or manual method as a restraint depends on the effect the device has on the individual. This can only be determined on a case-by-case basis by individually assessing each and every device (whether or not it is listed specifically on the MN/LOC) and its effect on the individual.
  7. Any device, material, or equipment that meets the definition of a physical restraint should have a plan of care and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

Coding Instructions

Identify all restraints that were used at any time (day or night) during the 7-day look-back period.

- After determining whether or not a device listed in (P0100) is a restraint and was used during the 7-day look-back period, code the frequency of use:
  - **Code 0, not used:** if the device was not used during the 7-day look-back **or** it was used but did not meet the definition.
  - **Code 1, used less than daily:** if the device met the definition and was used less than daily.
  - **Code 2, used daily:** if the device met the definition and was used on a daily basis during the look-back period.

Coding Tips and Special Populations

- Any device that does not fit into the listed categories but that meets the definition of a restraint and has not been excluded from this section should be coded in items P0100D or P0100H, Other. These devices should be included in the plan of care and monitored.

- In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the purpose or intent of its use. It is possible for a device to improve the individual's mobility and also have the effect of restraining him or her.
- Exclude from this section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).
- Bed rails include any combination of partial or full rails (For example, one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems.
- Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meets the definition of a physical restraint even though they may improve the individual's mobility in bed, the assessor must code their use as a restraint at P0100A.
    - Bed rails used with individuals who are immobile. If the individual is immobile and cannot voluntarily get out of bed because of a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.
    - For individuals who have no voluntary movement, the caregiver needs to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some individuals have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, individual weight, and gravity's effects may lead to the individual's body shifting toward the edge of the bed. When bed rails are used in these cases, the individual could be at risk for entrapment. For this type of individual, clinical evaluation of alternatives (For example, a concave mattress to keep the individual from going over the edge of the bed), coupled with frequent monitoring of the individual's position, should be considered. While the bed rails may not constitute a restraint, they may affect the individual's quality of life and create an accident hazard.
- Trunk restraints include any device or equipment or material that the individual cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair.
- Limb restraints include any device or equipment or material that the individual cannot easily remove, that restricts movement of any part of an upper extremity (That is hand, arm, wrist) or lower extremity (That is foot, leg). Included in this category are mittens.
- Trunk or limb restraints, if used in both bed and chair, should be marked in both sections.
- Chairs that prevent rising include any type of chair with a locked lap board, that places the individual in a recumbent position that restricts rising, or a chair that is soft and low to the floor. Included here are chairs that have a cushion placed in the seat that prohibit the individual from rising.
    - For individuals who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair **would be considered a restraint** to that individual, and should be coded as P0100G–Chair Prevents Rising.
    - Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a restraint. These types of walkers are only classified as a restraint if the individual cannot exit the gate. When deemed a restraint, these walkers should be coded at P0100G–Chair Prevents Rising.

- Geriatric chairs used for individuals who are immobile. For individuals who have no voluntary or involuntary movement, the geriatric chair **does not** meet the definition of a restraint.
- For individuals who have no ability to transfer independently, the geriatric chair **does not** meet the definition of a restraint, and should not be coded at P0100H–Other.

- Restraints used in emergency situations**.** If the individual needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed, unless the individual or legal representative has previously made a valid refusal of the treatment in question. The use of physical restraints in this instance should be limited to preventing the individual from interfering with life-sustaining procedures only and not for routine care.
- An individual who is injuring himself/herself or is threatening physical harm to others may be restrained in an emergency to safeguard the individual and others. An individual whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of restraints, as long as those restraints are used as a last resort to protect the safety of the individual or others and use is limited to the immediate episode

Additional Information

- Restraint reduction/elimination. For individuals whose plan of care indicates the need for restraints, a gradual process towards reducing (or eliminating, if possible) the restraints (For example, gradually increasing the time for ambulation and strengthening activities) should be employed.
- Restraints as a fall prevention approach. Although restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually **decrease** the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
- Request for restraints. As with other medical treatments, such as the use of prescription drugs, an individual, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary.
- Medical symptoms/diagnoses **-** are defined as an indication or characteristic of a physical or psychological condition. Objective findings derived from clinical evaluation of the individual's medical diagnoses and subjective symptoms should be considered when determining the presence of medical symptom(s) that might support restraint use. The individual's subjective symptoms may not be used as the sole basis for using a restraint. In addition, the individual's medical symptoms/diagnoses should not be viewed in isolation; rather, the medical symptoms identified should become the context in which to determine the most appropriate method of treatment related to the individual's condition, circumstances, and environment, and not a way to justify restraint use.
- The identification of medical symptoms should assist the caregiver in determining if the specific medical symptom can be improved or addressed by using other, less restrictive interventions. The caregiver should perform all due diligence and document this process to ensure that they have exhausted alternative treatments and less restrictive measures before a restraint is employed to treat the medical symptom, protect the individual's safety, help the individual attain or maintain his or her highest level of physical or psychological well-being and support the individual's goals, wishes, independence, and self-direction.
- Physical restraints as an intervention do not treat the underlying causes of medical symptoms.

Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom. Restraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent an individual from injuring himself/herself or others and/or to prevent the individual from interfering with life-sustaining treatment when no other less restrictive or less risky interventions exist.

- A clear link must exist between the restraint use and how it benefits the individual by addressing the specific medical symptom.

P0200: Alarms

P0200. Alarms	
An alarm is any phyiscal or electronic device that monitors resident movement and alerts the staff when movement is detected	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	☐ A. Bed alarm
	☐ B. Chair alarm
	☐ C. Floor mat alarm
	☐ D. Motion Sensor alarm
	☐ E. Wander/elopement alarm
	☐ F. Other alarm

Item Rationale

Health-related Quality of Life

- An alarm is any physical or electronic device that monitors individual movement and alerts the caregiver, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the individual's clothing, motion sensors, door alarms, or elopement/wandering devices.
- While often used as an intervention in an individual's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
- The use of an alarm as part of an individual's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
- Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

Planning for Care

- Individualized, person-centered care planning surrounding the individual's use of an alarm is important to the individual's overall well-being.
- When the use of an alarm is considered as an intervention in the individual's safety strategy, use must be based on the assessment of the individual and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of alarm use and alternative interventions.
- There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the individual's freedom of movement and may not be easily removed by the individual.

Steps for Assessment

1. Review the individual's medical record (For example, physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
2. Consult the caregiver to determine the individual's cognitive and physical status/limitations.
3. Evaluate whether the alarm affects the individual's freedom of movement when the alarm/device is in place. For example, does the individual avoid standing up or repositioning himself/herself due to fear of setting off the alarm?

Coding Instructions

An alarm is any physical or electronic device that monitors an individual's movement and alerts when movement is detected.

Enter Codes in Boxes:

- **Code 0, not used:** if the device was not used during the 7-day look-back **or** it was used but did not meet the definition.
- **Code 1, used less than daily:** if the device met the definition and was used less than daily.
- **Code 2, used daily:** if the device met the definition and was used on a daily basis during the look-back period.

Coding Tips and Special Populations

- **Bed alarm** includes devices such as a sensor pad placed on the bed or a device that clips to the individual's clothing.
- **Chair alarm** includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the individual's clothing.
- **Floor mat alarm** includes devices such as a sensor pad placed on the floor beside the bed.
- **Motion sensor alarm** includes infrared beam motion detectors.
- **Wander/elopement alarm** includes devices such as bracelets, pins/buttons worn on the individual's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the individual that alert the caregiver when the individual nears or exits an area or building. This includes devices that are attached to the individual's assistive device (For example, walker, wheelchair, cane) or other belongings.
- **Other alarm** includes devices such as alarms on the individual's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.
- Code any type of alarm, audible or inaudible, used during the look-back period in this section.
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.
- Motion sensors and wrist sensors worn by the individual to track the individual's sleep patterns should not be coded in this section.
- Wandering is random or repetitive locomotion. This movement may be goal-directed (for example, the individual appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.
- While wander, door, or building alarms can help monitor an individual's activities, staff must be

vigilant to respond to them in a timely manner. Alarms do not replace necessary supervision.

- Bracelets or devices worn or attached to the individual and/or his or her belongings that signal a door to lock when the individual approaches should be coded in P0200F Other alarm, whether or not the device activates a sound.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: The items in this section are intended to record the participation and expectations of the individual, family members, or significant other(s) in the assessment, and to understand the individual's overall goals.

Q0100: Participation in Assessment

Q0100. Participation in Assessment	
Enter Code ☐	A. Individual participated in assessment 0. No 1. Yes
Enter Code ☐	B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other available
Enter Code ☐	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative available

Item Rationale

Health-related Quality of Life

- Individuals who actively participate in the assessment process and in developing the care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- The plan of care should be person-centered and person-driven.
- Many individuals want their caregiver, family or significant other(s) to be involved in the assessment.
- When the individual is unable to participate in the assessment process, caregivers, family or significant others can provide valuable information about the individual's needs, goals, and priorities.

Coding Instructions for Q0100A, Individual Participated in Assessment

Record the participation of the individual in the assessment process.

- **Code 0, no:** if the individual did not actively participate in the assessment process.
- **Code 1, yes:** if the individual actively and meaningfully participated in the assessment process.

Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment

Record the participation of the family or significant other in the assessment process.

- **Code 0, no:** if the family or significant other did not participate in the assessment process.
- **Code 1, yes:** if the family or significant other(s) did participate in the assessment process.
- **Code 9, no family or significant other available:** if there is no family or significant other or none is available.

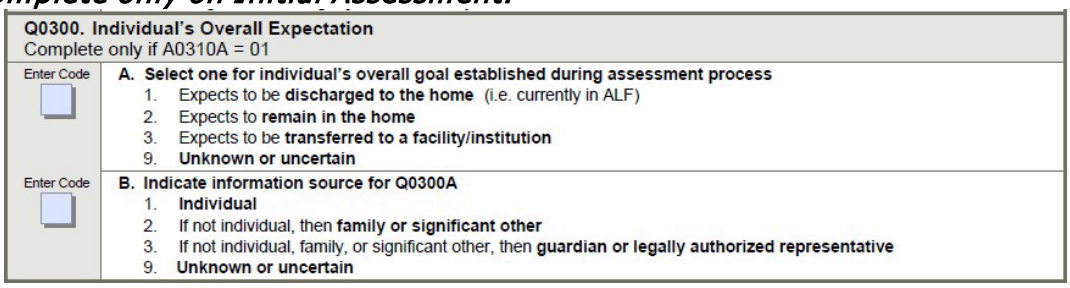
Coding Instructions for Q0100C, Guardian or LAR Participated in Assessment

Record the participation of the guardian or legally authorized representative in the assessment process.

- **Code 0, no:** if guardian or legally authorized representative did not participate in the assessment.
- **Code 1, yes:** if guardian or legally authorized representative did participate in the assessment process.
- **Code 9, no guardian or LAR available:** if there is no guardian or LAR or none is available.

Q0300: Individual's Overall Expectation

Complete only on Initial Assessment.



Q0300. Individual's Overall Expectation Complete only if A0310A = 01	
Enter Code	**A. Select one for individual's overall goal established during assessment process** 1. Expects to be **discharged to the home** (i.e. currently in ALF) 2. Expects to **remain in the home** 3. Expects to be **transferred to a facility/institution** 9. **Unknown or uncertain**
Enter Code	**B. Indicate information source for Q0300A** 1. **Individual** 2. If not individual, then **family or significant other** 3. If not individual, family, or significant other, then **guardian or legally authorized representative** 9. **Unknown or uncertain**

Item Rationale

This item identifies the individual's general expectations and goals for future living arrangements.

Health-related Quality of Life

- Unless the individual's goals for care are understood, the individual's needs, goals, and priorities are not likely to be met.

Planning for Care

- The individual's goals should be the basis for the plan of care.

Steps for Assessment

1. Ask the individual about his or her overall expectations to be sure that he or she has participated in the assessment process.
2. Ask the individual to consider his or her current clinical status, expectations regarding improvement or worsening, and social supports.
3. Because of a temporary (For example, delirium) or permanent (For example, profound dementia) condition, some individuals may be unable to provide a clear response. If the individual is unable to communicate his or her preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.
4. If goals have not already been stated directly by the individual, ask the individual directly about what his or her expectation is regarding future living arrangements
5. The individual's goals—as perceived by the family, significant other, guardian, or legally authorized representative—should be recorded here only if the individual is unable to discuss his or her goals.
6. Encourage the involvement of family or significant others in the discussion, if the individual consents. Family, significant others, or, if necessary, the guardian or legally authorized representative can be involved if the individual is uncertain about his or her goals. The response selected must reflect the individual's perspective if he or she is able to express it.

Coding Instructions for Q0300A, Individual's Overall Goals Established during Assessment…

Record the individual's expectations as expressed by her or him. It is important to document their expectations.

- **Code 1, expects to be discharged to the home (That is currently in ALF)**
- **Code 2, expects to remain in the home.**

- **Code 3, expects to be transferred to a facility/institution.**
- **Code 9, unknown or uncertain**: if the individual is uncertain or is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative are not available to participate in the discussion.

Coding Tips

- This item is person-centered and focuses on exploring the individual's expectations; not whether or not others consider them to be realistic.
- Avoid trying to guess what the individual might identify as a goal or to judge the individual's goal. Do not infer based on a specific advance care order, such as "do not resuscitate" (DNR).

Coding Instructions for Q0300B, Indicate Information Source for Q0300A

- **Code 1, individual:** if the individual is the source for completing this item.
- **Code 2, if not individual, then family or significant other:** if the individual is unable to respond and family member or significant other is the source for completing this item.
- **Code 3, if individual, family or significant other, then guardian or legally authorized representative:** if the guardian or legally authorized representative is the source for completing this item because the individual is unable to respond and family member or significant other is not available to respond.
- **Code 9, unknown or uncertain (none of the above):** if the individual cannot respond and the family or significant other, or guardian or legally authorized representative cannot be contacted or is unable to respond.

Example

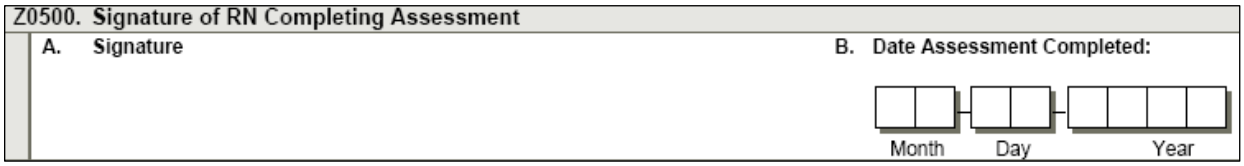
1. Mr. W. is a 73-year-old man who has severe heart failure and renal dysfunction. He also has a new diagnosis of metastatic colorectal cancer. He receives nursing and attendant services through the community program. He indicates that he is "strongly optimistic" about his future and only wants to think "positive thoughts" about what is going to happen and needs to believe that his health will improve and that he will be able to remain in his home.

   Coding: Q0300A would be coded as **2, expects to remain in the home.**
   Rationale: Mr. W has a clear goal to get well, even if this is unlikely based on medical diagnosis and current medical problems. This item should be coded based on the individual's expressed goals.

SECTION Z: ASSESSMENT ADMINISTRATION

Intent: The intent of this section is to provide the signature of the RN completing the assessment.

Z0500: Signature of RN Completing Assessment



Item Rationale

Regulations require the RN to sign and thereby certify that the assessment is accurate and complete.

Steps for Assessment

1. Verify that all items on this assessment are complete.

Coding Instructions

- For Z0500B, use the actual date that the assessment was completed. If for some reason the assessment cannot be signed by the RN on the date it is completed, the RN should use the date that it is signed.

Example

1. A nurse assessor completes the face to face assessment on March 15, 2025. She does not receive all documentation required to complete the assessment (For example, the physician's signature, information from the physical therapist, etc.) until March 23, 2025. The nurse assessor should enter March 23, 2025 in field Z0500B.

LTC Medicaid Information

S1. Medicaid Information

S1a. Medicaid Client Indicator

- This field will be auto-populated.

S1b. Individual Address (Required)

- Enter the street address where the individual is presently living.
- Individual's Address is used for mailing Medical Necessity (MN) letters.

S1c. City (Required)

- Enter the city where the individual is presently living.
- If a city has a hyphen in the city name, replace the hyphen with a space.
- If a city has an apostrophe in the city name, enter the city name without the apostrophe.

S1d. State (Required)

- Enter the state where the individual is presently living.

S1e. Zip Code (Required)

- Enter the zip code where the individual is presently living.

S1f. Phone Optional

- Enter the contact phone number for the individual if known.
- If individual does not have a contact phone number, enter 000-000-0000.

S2. Claims Processing Information

S2a. DADS Vendor/Site ID Number

- This field will be auto populated based on the user's logon security credentials.
- This field is not correctable on the TMHP LTC Online Portal.

S2b. Provider Number

- This field is not correctable on the TMHP LTC Online Portal.
- If a National Provider Identifier (NPI) has more than one provider number associated, be sure the correct provider number is selected from the drop-down box.

S2c. Service Group (Required)

May be prepopulated, if not, choose from the drop down menu

11. PACE
18. MDCP
19. SPW
23. CFC

S2d. NPI Number

- Enter your NPI number.
- DADS Regional Nurses will enter their Atypical (API) number. Atypical numbers will usually consist of a "D" and the contract number.
- This field cannot be corrected once an assessment has been submitted.

S2e. Region

Choose the provider's region from the list provided.

01 – Lubbock	05 – Beaumont	09 – Midland / Odessa
02 – Abilene	06 – Houston	10 – El Paso
03 – Grand Prairie	07 – Austin	11 – Edinburg
04 – Tyler	08 – San Antonio	

S2f. Purpose Code

- Code is auto-populated when a Utilization Review Assessment is submitted. For Initial, Annual and SCSA assessments, this field is not available for data entry.
- This field is not able to be modified.
- This field cannot be corrected once an assessment has been submitted.

S2g. HHA License # (Required)

- If you work for a Home Health Agency (HHA), enter the Home Health Agency License number.
- HHA License # must be up to 7 numeric digits.
- If you do not work for a Home Health Agency (HHA), or you are an MDCP nurse completing the MN/LOC, enter all zeros.

S2h. HHA License # Expiration Date (Required)

- Enter the license expiration date of the Home Health Agency License number.
- HHA License # Expiration Date must be in mm/dd/yyyy format.

S3. Primary Diagnosis

S3a. Primary Diagnosis ICD Code

- Enter a valid ICD code for the individual's primary diagnosis. This diagnosis should be the one that most significantly contributes to the individual's need for the services of a licensed nurse.

S3b. Primary Diagnosis ICD Description

- Click the magnifying glass and the description will be auto populated based on the primary diagnosis ICD code.

S4. For DADS use only

S4a. MN
S4b. PDPM LTC
S4c. Effective Date
S4d. Expiration Date
S4e. County
S4f. DADS RN Signature
S4g. Signature Date

S5. Licenses

Certification

"To the best of my knowledge, I certify to the accuracy and completeness of this information."

S5a. HHA RN Last Name (Conditional)
Required if Service Group = 3.

- Enter the last name of the RN completing the assessment.

S5b. HHA RN License # (Conditional)
Required if Service Group = 3.

- Enter the license number of the RN.
- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure PDPM LTC training requirements have been met.

S5c HHA RN License State (Conditional)
Required if Service Group = 3.

- Enter the state in which the RN is licensed.

S5d DADS RN Last Name (Conditional)
Required if Service Group = 18 OR Purpose code = 1 (UR)

- Enter the last name of the RN completing the assessment.

S5e DADS RN License # (Conditional)
Required if Service Group = 18 OR Purpose code = 1 (UR) Enter the license number of the RN.

- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure PDPM LTC training requirements have been met.

S5f DADS RN License State (Conditional)
Required if Service Group = 18 OR Purpose code = 1 (UR)

- Enter the state in which the RN is licensed.

S5g DADS RN Signature Date (Conditional)
Required if Service Group = 18 OR Purpose code = 1 (UR)

- Enter the date the DADS RN signed the assessment as being complete.

DADS RN Signature

- DADS Nurse must sign assessment as being complete.

S5h PACE RN Last Name (Conditional)
Required if Service Group = 11.

- Enter the last name of the RN completing the assessment.

S5i PACE RN License # (Conditional)
Required if Service Group = 11

- Enter the license number of the RN.
- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure PDPM LTC training requirements have been met.

S5j PACE RN License State (Conditional)
Required if Service Group = 11.

- Enter the state in which the RN is licensed.

S5k HMO RN Last Name (Conditional)
Required if Service Group = 19.

- Enter the last name of the RN completing the assessment.

S5l HMO RN License # (Conditional)
Required if Service Group = 19.

- Enter the license number of the RN.
- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure PDPM LTC training requirements have been met.

S5m HMO RN License State (Conditional)
Required if Service Group = 19.

- Enter the state in which the RN is licensed.

S6. Additional MN Information

S6a. Tracheostomy Care (Conditional)
This is a required field only available for data entry if O0100E, Tracheostomy care, is checked AND the individual is less than 22 years of age.

- Enter the number corresponding to the appropriate response.

  1 = Less than once a week
  2 = 1 to 6 times a week
  3 = Once a day
  4 = Twice a day
  5 = 3 – 11 times a day
  6 = Every 2 hours
  7 = Hourly / continuous

S6b. Ventilator / Respirator (Conditional)
This is a required field only available for data entry if O0100F, ventilator or respirator, is checked. Do not include BiPAP/CPAP.

- Enter the number corresponding to the appropriate response.

  1 = Less than once a week
  2 = 1 to 6 times a week
  3 = Once a day
  4 = Twice a day
  5 = 3 – 11 times a day
  6 = 6 – 23 hours
  7 = 24-hour continuous

S6c. Number of hospitalizations in the last 90 days (90-Day Look-back) (Required)

- Record the number of times the individual was admitted to hospital with an overnight stay in the last 90 days (or since last assessment if less than 90 days). Enter 0 (zero) if no hospital admissions.
- Valid range includes 0 – 90.

S6d. Number of emergency room visits in the last 90 days (90-Day Look-back) (Required)

- Record the number of times the individual visited the Emergency Room (ER) without an overnight stay in the last 90 days (or since last assessment if less than 90 days). Enter 0 (zero) if no ER visits.
- Valid range includes 0 – 90.

S6e. Oxygen Therapy (Conditional)
This is a required field only available for data entry if O0100C, Oxygen therapy, is checked.

- Enter the number corresponding to the appropriate response.

  1 = Less than once a week
  2 = 1 to 6 times a week
  3 = Once a day
  4 = Twice a day
  5 = 3 – 11 times a day
  6 = 6 – 23 hours
  7 = 24-hour continuous

S6f. Special Ports/Central Lines/PICC (Optional)

- Use this field to indicate if the individual has any type of implantable access system or central venous catheter (CVC). This includes epidural, intrathecal or venous access or Peripherally Inserted Central Catheter (PICC) devices. This does NOT include hemodialysis or peritoneal dialysis access devices.
- Enter the corresponding value to the most appropriate response:

  N = none present
  Y = 1 or more implantable access system or CVC
  U = unknown

S6g. At what developmental level is the individual functioning? (Conditional)
This is a required field for all assessments for individuals under age 21 based on birth date minus date of submission (TMHP Received date). Not available for data entry if the individual is 21 or older.

- Field is correctable. Responses included in drop down are:

< 1	Infant
1 – 2	Toddler
3 – 5	Pre-School
6 – 10	School age
11 – 15	Young Adolescence
16 – 20	Older Adolescence
` – `	Unknown or unable to assess choose the dash.

S6h. Enter the number of times this individual has fallen in the last 90 days. (90-Day Look-back) (Required)

- Record number of times the individual has fallen in the last 90 days. Enter 0 (zero) if no falls.
- Each fall should be counted separately so if the individual has fallen multiple times in one day, count each fall individually.
- Valid range includes 0 – 999.

Pediatric Tip

Code reported falls even in situations when the falls are expected, for example, a toddler learning to walk or a child with cerebral palsy.

S6i. In how many of the falls listed in S6h above was the individual physically restrained prior to the fall? (Conditional)
This is a required field only if S6h indicates the individual has fallen.

- Valid range includes 0 with a maximum being the number entered in S6h.
- Enter 0 if no falls when the individual was physically restrained prior to the fall.

S6j. In the falls listed in S6h above, how many had the following contributory factors?

- More than one factor may apply to a fall. Indicate the number of falls, for each contributory factor.

S6j1 through S6j6 are required fields only if S6h indicates the individual has fallen.
(Valid range includes 0 with a maximum being the number entered in S6h.)

S6j1-Environmental (debris, slick or wet floors, lighting, etc.)

S6j2-Medication(s)

S6j3-Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)

S6j4-Poor Balance/Weakness

S6j5-Confusion/Disorientation

S6j6-Assault by Individual or Caregiver

S7. Physician's Evaluation and Recommendation

S7a. Did an MD/DO certify that this individual requires nursing facility services or alternative community based services under the supervision of an MD/DO? Y/N (Conditional)
This is a required field for the Initial Assessment. This field is optional for Annual and SCSA Assessments.

- To meet the requirements for these community programs, the individual must require nursing facility services or alternative community based services under the supervision of an MD or DO. Submission of the assessment will not be allowed on the TMHP LTC Online Portal if N (no) is selected.
- This is a required field for the Initial Assessment. This field is optional for Annual and SCSA Assessments.

S7b. Did a military physician providing healthcare according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual? Y/N (Required)

- If the licensed physician providing healthcare to this individual is practicing in a health care facility of the Department of Defense (DOD), a civilian facility affiliated with the DOD, or any other location authorized by the Secretary of Defense, and is not licensed by the State of Texas, answer Y (yes) to this item. If the answer is Y, complete S7f through S7k.
- If the answer to this item is Y (yes) a physician name and permanent license number from any of the 50 states, the District of Columbia, or United States territories is acceptable.
- If the answer to this item is N (no) a physician name and permanent license number from the following states is acceptable: Texas, Louisiana, Arkansas, Oklahoma and New Mexico.

S7c. MD/DO Last Name (Required)

- Enter the last name of the MD/DO.

S7d. MD/DO License # (Required)

- Enter the license number of the MD/DO.
- This number is validated against the applicable State Medical Board file.
- Physicians are not required to complete the PDPM LTC training.
- Only permanent license numbers will be accepted.

S7e. MD/DO License State (Required)

- Enter the state in which the MD/DO is licensed.
- For non-military physicians, only physicians from Texas and the four states contiguous to Texas are acceptable (Louisiana, Arkansas, Oklahoma, and New Mexico).
- Indicate Physician Signature on file by checking box.
- The box next to the statement "Indicate Physician Signature on file by checking box" is required to be checked for Initial Assessments; it is optional for Annual and SCSA Assessments.

S7f through S7j is required information if the MD/DO is not licensed in Texas.
Enter the address and phone number of the military facility in which the physician providing the evaluation and recommendation practices in S7g-S7k. This information will be used to mail MN determination letters.

S7f. MD/DO First Name (Conditional)
Required field if S7e License State is NOT Texas.

- Enter the first name of the individual's MD/DO.
- This information is used to mail MN determination letters.

S7g. MD/DO Address (Conditional)
Required field if S7e License State is NOT Texas.

- Enter the street address of the individual's MD/DO.
- This information is used to mail MN determination letters.

S7h. MD/DO City (Conditional)
Required field if S7e License State is NOT Texas.

- Enter the city of the individual's MD/DO mailing address.
- This information is used to mail MN determination letters.
- If a city has a hyphen in the city name, replace the hyphen with a space.
- If a city has an apostrophe in the city name, enter the city name without the apostrophe.

S7i. MD/DO State (Conditional)
Required field if S7e License State is NOT Texas.

- Enter the state of the individual's MD/DO mailing address.
- This information is used to mail MN determination letters.

S7j. MD/DO ZIP code (Conditional)
Required field if S7e License State is NOT Texas.

- Enter the ZIP code of the individual's MD/DO mailing address.
- This information is used to mail MN determination letters.

S7k. MD/DO Phone (Conditional)
Optional field if S7e License State is NOT Texas.

- Enter the phone number of the individual's MD/DO.
- This information is used to contact MD/DO if necessary.

S9. Medications (30-Day Look-back)

S9.0 Medication Certification (Required)
"I certify this individual is taking no medications" OR "the medications listed below are correct."

- Check the Medication Certification box to verify
  - The individual has no medications, OR
  - That the individual has medications and they are listed correctly in the medication table to include name, dose, route of administration (RA), frequency (Freq), and as necessary – number of doses (PRN-n).
- The coding instructions are extensive. Review them carefully. Study the examples and complete the coding exercise at the end of this section.

S9.1 Medication Name and Dose Ordered

Identify and record all medications that the individual received in the last 30 days. Also identify and record any medications that may not have been given in the last 30 days, but are part of the individual's regular medication regimen (For example, monthly B-12 injections). Do not record PRN medications that were not administered in the last 30 days.

- Record the name of the medication and dose that was ordered by the physician in column 1.
- Code only medications that the physician orders. If a medication is administered outside of the individual's residence, (For example, a dose administered at an Adult Day Care facility or a dialysis center), that should be included here. (Dialysis itself is captured in O0100J.)
- When an oral medication is crushed and administered via G-tube, use code 9, enteral tube. A note of caution: some oral medications should not be crushed.
- Stat orders are coded as 1 in the PRN column.
- All medications received by the individual, including over-the-counter medications ordered by the physician should be included.
- Record the total number of doses (not days) of the PRN medication given (30 day look-back).

EXAMPLE FOR 1. MEDICATION NAME AND DOSE ORDERED

Medications for assessment period of 8/11/10-9/9/10

A. Lasix 40 mg daily p.o.
B. Acetaminophen 325 mg 2 tabs q3-4 hrs. PRN p.o. (given 3 times in last 30 days)
C. B-12 1cc q month IM (given 8/8/10)
D. Isopto Carbachol 1.5 percent 2 drops OD TID
E. Robitussin-DM 5cc HS PRN p.o. (not given in last 30 days)
F. Motrin 300 mg QID p.o. (discontinued 8/15/10)
G. Dilantin 300 mg HS p.o. (ordered 8/15/10)
H. Theo-Dur 200 mg BID p.o. (given 8/11-8/13/10 and then order discontinued)
I. Theo-Dur 200 mg TID p.o. (given 8/14-8/16/10 and then order discontinued)
J. Theo-Dur 400 mg BID p.o. (given 8/02/10)

Complete Column 1 as follows:

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Lasix 40 (mg)			
Acetaminophen (325 mg) 2 tabs			
B-12 (1 cc)			
Isopto Carbachol (1.5 percent) 2Drops			
Motrin (300 mg)			
Dilantin (300 mg)			
Theo-Dur (200 mg)			
Theo-Dur (200 mg)			
Theo-Dur (400 mg)			

**Note:* that Robitussin-DM was not recorded because it was not given in the last 30 days.*

S9.2 Route of Administration (RA)

- Determine the RA used to administer each medication. The physician's orders should identify the RA for each medication. Record the RA in column 2 using the following codes:

1 = by mouth (PO)	5 = subcutaneous (SQ)	8 = inhalation
2 = sub lingual (SL)	6 = rectal (R)	9 = enteral tube
3 = intramuscular (IM)	7 = topical	10 = other
4 = intravenous (IV)		

EXAMPLE FOR 2. ROUTE OF ADMINISTRATION

Medications for assessment period of 8/11/10-9/9/10

A. Mylanta 15 cc after meals p.o.
B. Zantac 150 mg q 12 hrs. Per tube
C. Transderm Nitro patch 2.5 1 patch daily
D. NPH 15 U before breakfast daily SQ
E. Lasix 80 mg IV STAT
F. Acetaminophen suppository 650 mg. q 4 hrs.
G. PRN (given on 2 occasions in last 30 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Mylanta (15 cc)	1		
Zantac (150 mg)	9		
Transderm Nitro patch (2.5) 1 patch	7		
NPH (15 U)	5		
Lasix (80 mg)	4		
Acetaminophen suppository (650 mg)	6		

S9.3 Frequency (Freq)

- Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3 using the following codes:

PR = (PRN) as necessary	2D = (BID) two times daily (includes every 12 hrs.)	QO = every other day
1H = (QH) every hour		4W = 4 times each week
2H = (Q2H) every two hours	3D = (TID) three times daily	5W = five times each week
3H = (Q3H) every three hours	4D = (QID) four times daily	6W = six times each week
4H = (Q4H) every four hours	5D = five times daily	1M = (Q mo) once every month
6H = (Q6H) every six hours	1W = (Q week) once each wk	2M = twice every month
8H = (Q8H) every eight hours	2W = two times every week	C = continuous
1D = (QD or HS) once daily	3W = three times every week	O = other

- Be careful to differentiate between similar frequencies. For example, if an antibiotic is ordered as T.I.D., the medication may actually be given q 8 hours. There is a different frequency code for
- T.I.D. (3D) and q 8 hrs. (8H). If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Ampicillin 250 mg	1	6h	
Beconase nasal inhaler 1 puff	8	2d	
Compazine suppository 5 mg	6	PR	
Lanoxin 0.25 mg	1	QO	
Lanoxin 0.125 mg	1	QO	
Peri-colace 2 capsules	1	1D	
NPH 15 U	5	1D	
NPH 5 U	5	PR	
NPH 10 U	5	PR	

S9.4 PRN-Number of Doses (PRN-n)

- The PRN-n column is only completed for medications that have a frequency as PR. Record the number of times in the past 30 days that each medication coded as PR was given. Stat medications are recorded as a PRN medication. Remember, if a PRN medication was not given in the past 30 days, it should not be listed here.

Coding Exercises for S9 Medications

Complete the practice form on the next page for the following medications during a 30-day period (8/11/10 - 9/9/10):

1. Inderal 40 mg BID p.o.
2. Sinemet 10/100 TID p.o.
3. Artificial Tears 1 drop OU QID
4. Anusol HC suppository 1 PRN (given 1 time in last 30 days)
5. Amoxicillin 500 mg q 6 hrs. per tube
6. Benylin cough syrup 2 tbs PRN p.o. (given 10 times in last 30 days)
7. Darvocet-N 100 2 tabs q 4-6 hrs. PRN p.o. (given 5 times in last 30 days)
8. Heparin lock flush 10 U daily
9. Ditropan syrup 2.5 mg daily p.o.
10. Nitrotransdermal .4 mg 1 patch daily
11. Novolin N 24 U before breakfast SQ
12. Check blood sugar before breakfast. Sliding scale insulin: Novolin R 10 units if blood sugar over 200. (10 units given on 2 days in last 30 days)
13. Questran 1 packet with each meal p.o.
14. Quinine sulfate 325 mg HS
15. Coumadin 2.5 mg daily p.o. (discontinued 9/3/10)
16. Coumadin 5 mg daily p.o. (ordered to start on 9/4/10)
17. Maalox 15 cc PRN for indigestion p.o. (not administered in last 30 days)

Exercise: Practice using the table below and compare with the answers on the next page

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n

S9. Medications exercise answer form:

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Inderal 40 mg.	1	2D	
Sinemet 10/100	1	3D	
Artificial Tears 1 drop	7	4D	
Anusol HC suppository 1	6	PR	1
Amoxicillin 500 mg	9	6H	
Benylin cough syrup 2 Tbs	1	PR	10
Darvocet-N 100 2 tabs	1	PR	5
Heparin lock flush 10 U	4	1D	
Ditropan syrup 2.5 mg	1	1D	
Nitrotransdermal .4 mg	7	1D	
Novolin N 24 U	5	1D	
Novolin R 10 U	5	PR	2
Questran 1 packet	1	3D	
Quinine sulfate 325 mg	1	1D	
Coumadin 2.5 mg	1	1D	
Coumadin 5 mg	1	1D	

S10. Comments

The comment section is an extension of the MDS information and should not contradict what has been entered into the MDS sections. (For example, the comments state that the individual has issues with behaviors, wandering and elopement, but this is not coded in the MDS). The following should also be considered:

- Adding comments is optional
- Enter up to 500 characters; It is essential that you include signs and symptoms that present an accurate picture of the client's condition. Include why those signs and symptoms can only be managed in a nursing facility.
- The comment section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:
    - Pertinent medical history
    - Ability to understand changes in condition
    - Abnormal vital signs/lab work that require monitoring by a licensed or registered nurse in a facility-based setting.
    - Previous attempts at outpatient management of medical condition such as Home Health Services, Rehabilitative Services.
    - If a cognitive deficit is present and this is not adequately captured in Section C of the MDS, Brief Interview of Mental Status, (BIMS), a brief explanation of the reason there might be a discrepancy at the time of the LTCMI completion could be added. (For example, the MDS scores the BIMS at a 15, showing they are cognitively intact, but their mentation can change throughout the day, resulting in the need for closer supervision).

Medical Necessity

The comment section is a way to provide information that may not be clearly represented in the MDS. To qualify for Medical Necessity, the following is required:

- The individual must have a medical condition that is of significant seriousness that their needs exceed the routine care which may be given by an untrained person;
- Skilled nursing level of care must be ordered by a physician;
- Are dependent upon the individual's documented medical conditions;
- The individual must require the skills of a registered or licensed nurse;
- Services that are provided either directly or under the supervision of a licensed nurse in an institutional setting and are required on a regular basis.
- The individual requires licensed nurses' supervision, planning, and intervention that are only available in an institution.

Pediatric Tip

- When chest physiotherapy techniques (CPT) including percussion and postural drainage, use of a high-frequency chest wall oscillation device (ThAIRapy Vest), intrapulmonary percussive ventilator (IPV) are administered by an individual who is not a licensed Respiratory Therapist (That isan RN, LVN, or trained caregiver) it should be noted in Comments.
- Nebulizer treatments administered by family members (or other individuals, non-licensed or not delegated to under the license of a nurse) are not coded in O0400D1; in this case nebulizer treatments should be entered in section S9, Medications, and may also be noted in Comments.

S11. Advance Care Planning

What is Advance Care Planning?

Advance care planning means planning ahead for how the individual wants to be treated if ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die they are not able to talk or to let others know how they feel. It is a 5-step process that should be discussed with the individual.

1. Thinking about what you would want to happen if you could not talk or communicate with anyone
2. Finding out about what kind of choices you will need to make if you become very ill at home, in a nursing home or in a hospital
3. Talking with your family and doctor about how you want to be treated
4. Filling out papers that spell out what you want if you are in an accident or become sick
5. Telling people what you have decided

S11a. Does the individual/caregiver report that the individual has a legally authorized representative? Y/N (Required)

- A "Legally Authorized Representative (LAR)" is a person authorized by law to act on behalf of a person with regard to a matter described in this chapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult. A parent is authorized by law to act on behalf of their minor child.
- This fied is correctable. To answer:

  Enter Y = Yes.
  Enter N = No.

S11b. Does the individual/caregiver report that the individual has a Directive to Physicians and Family or Surrogates? (Required)

- A "Directive to Physician" is a document that communicates an individual's wishes about medical treatment at some time in the future when he or she is unable to make their wishes known because of illness or injury.
- This fied is correctable. To answer:

  Enter Y = Yes.
  Enter N = No.

S11c. Does the individual/caregiver report that the individual has a Medical Power of Attorney? (Required)

- This fied is correctable. To answer:

  Enter Y = Yes.
  Enter N = No.

S11d. Does the individual/caregiver report that the individual has an Out-of-Hospital Do-Not- Resuscitate Order? (Required)

What is an Out-of-Hospital Do Not Resuscitate Order (OOHDNR)?

This form is for use when an individual is not in the hospital. It lets the person tell health care

workers, including Emergency Medical Services (EMS) workers, NOT to do some things if the person stops breathing or their heart stops. If an individual does not have one of these forms filled out, EMS workers will ALWAYS give the person Cardiopulmonary Resuscitation (CPR) or advanced life support even if the advance care planning forms say not to. A person should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power of Attorney form if they do NOT want CPR.

- This field is correctable. To answer:

  Enter Y = Yes.
  Enter N = No.

S12. LAR Address

Legally Authorized Representative (LAR) address and name are required if S11a Is indicated as "Y – Yes," for the question, "Does the individual report having a legally authorized representative?"

S12a. LAR First Name

- Enter the first name of the Legally Authorized Representative.

S12b. LAR Last Name

- Enter the last name of the Legally Authorized Representative.

S12c. Address

- Enter the street address of the Legally Authorized Representative.

S12d. City

- Enter the city of the Legally Authorized Representative.
- If a city has a hyphen in the city name, replace the hyphen with a space.
- If a city has an apostrophe in the city name, enter the city name without the apostrophe.

S12e. State

- Enter the state of the Legally Authorized Representative.

S12f. ZIP Code

- Enter the zip code of the Legally Authorized Representative.

S12g. Phone (Optional)

- Enter the contact phone number for the Legally Authorized Representative if known.

Appendix I – Revisions Table

Date	Action	Section	Change
09 / 2025	Removed	Table of Contents and entire document	Removed references to ®
09 / 2025	Added	OVERVIEW TO THE 3.0 MN/LOC ITEM-BY-ITEM GUIDE	Included PDPM LTC information and note
09 / 2025	Changed	OVERVIEW TO THE 3.0 MN/LOC ITEM-BY-ITEM GUIDE	Changed Section G to Section GG: Functional Abilities
09 / 2025	Changed	OVERVIEW TO THE 3.0 MN/LOC ITEM-BY-ITEM GUIDE	Changed Section P: Restraints to Section P: Restraints and Alarms
09 / 2025	Changed	Purpose	Changed "Purpose" to "Purpose of the MN/LOC Item-by-Item Guide and added a note
09 / 2025	Changed	Medical Necessity and Level of Care Assessment Purpose	Changed RUG to PDPM LTC
09 / 2025	Changed	RUG Training	Changed RUG to PDPM LTC Training and removed information about license numbers being associated with the assessments
09 / 2025	Changed	When to Complete and Submit an Assessment	Changed RUG to PDPM LTC
09 / 2025	Changed	Assessment Retention	Changed "DADS" to "HHSC" and changed Section G to Section GG and added a note
09 / 2025	Changed	A0310: Type of Assessment	Changed RUG to PDPM LTC
09 / 2025	Removed	A0900: Birth Date	Removed Note
09 / 2025	Changed	SECTION C: COGNITIVE PATTERNS	Added clarifying information for BIMS
09 / 2025	Added	C0200: Health-related Quality of Life	Added "a memory impairment" and Inattention may be a sign of delirium or another health issue
09 / 2025	Changed	C0300, Examples	Changed 2012 to 2025
09 / 2025	Changed	C0300C, Examples	Changed 2012 to 2025
09 / 2025	Deleted	SECTION G: FUNCTIONAL STATUS	Item and instructions removed for Section G
09 / 2025	Added	Section GG: Functional Abilities	Added Section GG item and instructions
09 / 2025	Added	GG0100. Prior Functioning: Everyday Activities	Added Item Rationale, Steps for Assessment, Coding Instructions, Coding Tips, and Examples for Coding Prior Functioning: Everyday Activities
09 / 2025	Added	GG0110: Prior Device Use	Added Item Rationale, Steps for Assessment, Coding Instructions, Coding Tips, and Examples
09 / 2025	Added	GG0115: Functional Limitation in Range of Motion	Added Intent, Item Rationale, Steps for Assessment, Coding Tips, and Coding Instructions for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); GG0115B, Lower Extremity (Hip, Knee, Ankle, Foot)
09 / 2025	Added	GG0120: Mobility Devices	Added Item Rationale, Steps for Assessment, Coding Instructions, and Examples
09 / 2025	Added	GG0130: Self-Care (3-day assessment period) Admission	Added Item Rationale, Steps for Assessment, Coding Instructions, Assessment Period, Coding Tips, and Examples
09 / 2025	Added	GG0170: Mobility (3-day assessment period) Admission	Added Item Rationale, Steps for Assessment, Coding Instructions, Assessment Period, Coding Tips, and Examples
09 / 2025	Changed	O0600: Physician Examinations	Replaced RUG related information with PDPM LTC
09 / 2025	Changed	O0700, Coding Tips	Changed RUG to PDPM LTC Level
09 / 2025	Changed	SECTION P: RESTRAINTS AND ALARMS	Changed DADS to HHSC

09 / 2025	Changed	Section LTC Medicaid Information	Changed S1. Medicaid Information to S1. Claims Processing Information, Changed S1b. Individual Address to S1b. Provider Number, Changed S1e. Zip Code to S1e. Purpose Code, Changed S1f. Phone to S1f. Missed Assessment or Prior Start Date (the first date the facility was not paid), Changed S2. Claims Processing Information to S2. PASRR Information
09 / 2025	Changed	Appendix I – Revision Table	Reversed order of revision table (Newest items now appear at the top of the section)
10 / 2018	Added	J2000: Prior Surgery	New Item: This item identifies whether an individual has had major surgery during the 100 days prior to this assessment. A recent history of major surgery can affect an individual's care and recovery.
10 / 2018	Changed	Section M Intro Note	Added the word "Injury" after ulcer
10 / 2018	Changed	M0100	Added the word "Injury" after ulcer
10 / 2018	Changed	M100A	Added the word "Injury" after ulcer
10 / 2018	Changed	M0150	Added the word "Injury" after ulcer
10 / 2018	Changed	M0210	Added the word "Injury" after ulcer
10 / 2018	Changed	M0300	Added the word "Injury" after ulcer
10 / 2018	Changed	M0300A	Added the word "Injury" after ulcer
10 / 2018	Deleted	M0300B3	Deleted
10 / 2018	Changed	M0300D1	Added the word "Injury" after ulcer
10 / 2018	Changed	M0300E	Added the word "Injury" after ulcer
10 / 2018	Changed	M0300G	Added the word "Injury" after ulcer
10 / 2018	Deleted	M0610	Deleted
10 / 2018	Deleted	M0700	Deleted
10 / 2018	Changed	M1200	Added the word "Injury" after ulcer
10 / 2018	Changed	M1200E	Added the word "Injury" after ulcer
10 / 2018	Changed	O0100F	Invasive Mechanical Ventilator
10 / 2018	Changed	O0100G	Non-invasive Mechanical Ventilator (BiPAP/CPAP)
10 / 2017	Added	N0410H Opioid	New item
10 / 2017	Added	N0410 Medications Received	Added to coding tips diagnoses information related to new item: Opioid.
10 / 2017	Changed	Section P	Updated Intent section to reflect addition of "Alarms."
10 / 2017	Added	P0200 Alarms	New item
10 / 2016	Deleted	Overview	All references to Community Based Alternative (CBA)
10 / 2016	Added	B0100 Comatose	Added coding tip
10 / 2016	Changed	C0500 Cognitive Patterns	Changed item label from "Summary Score" to" BIMS Summary Score"
10 / 2016	Changed	C0600: Should the Caregiver Assessment for Mental Status be Conducted?	Changed Options 0 and 1 from "complete interview" to "complete Brief Interview for Mental Status" Changed "Skip to C1300" to "Skip to C1310"
10 / 2016	Deleted	C1300 Signs and Symptoms of Delirium (from CAM©)	Replace with new Delirium item: C1310
10 / 2016	Added	C1310 Signs and Symptoms of Delirium (from CAM©)	New Delirium item: Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record Footnote: Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. (Adapted from: Inouye SK et al. Ann - Intern Med. 1990; 113:941-8. Used with permission)

10 / 2016	Added	C1310A Acute onset Mental Status Change	New item: Is there evidence of an acute change in mental status from the individual's baseline? 0. No 1. Yes
10 / 2016	Added	C1310B-C1310D Inattention, Disorganized thinking, Altered level of consciousness	New items coding instructions: Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)
10 / 2016	Added	C1310B Inattention	New item: B. Did the individual have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?
10 / 2016	Added	C1310C Disorganized thinking	New item: Was the individual's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
10 / 2016	Added	C1310D Altered level of consciousness	New item: Did the individual have altered level of consciousness as indicated by any of the following criteria? * vigilant - startled easily to any sound or touch * lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch * stuporous - very difficult to arouse and keep aroused for the interview *comatose – could not be aroused
10 / 2016	Deleted	C1600 Acute Onset Mental Status change	Item deleted
10 / 2016	Added	I8000 Additional active diagnoses	Added to coding tips diagnoses codes prohibited from being entered.
10 / 2016	Changed	M0300G Unstageable- Deep tissue injury	Changed “Unstageable - Deep tissue” to “Unstageable - Deep tissue injury”
10 / 2016	Changed	M1040H Moisture Associated Skin Damage (MASD)	Changed "i.e. incontinence (IAD)" to "e.g., incontinence-associated dermatitis [IAD]".
10 / 2016	Changed	N0410 Medications Received	Changed instruction from “Indicate the number of DAYS the individual received the following medications during the last 7 days…” to “Indicate the number of DAYS the individual received the following medications by pharmacological classification, not how it is used, during the last 7 days…”
10 / 2016	Changed	N0410E Anticoagulant	Changed “warfarin” to “e.g., warfarin”