Optional State Assessment (OSA) Manual

Intent: The Optional State Assessment (OSA) item set may be required by a State Medicaid Agency to calculate the Resource Utilization Group (RUG)-III or RUG-IV case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes. Several items—A0300, D0200, D0300, G0110, K0510, O0100, O0450, O0600, O0700, and X0570—that have been removed from all Federally required item sets remain on the OSA for the purpose of calculating RUG-III/RUG-IV HIPPS codes. Instructions for completing these items are included in this manual. Instructions for completing other items on the OSA can be found in the respective sections of Chapter 3 of the Minimum Data Set (MDS) *Resident Assessment Instrument (RAI) 3.0 User's Manual*. The guidance in the OSA Manual should only be applied when completing an OSA for payment purposes. Providers should use the guidance in the MDS *RAI 3.0 User's Manual* to guide their completion of Federally required assessments.

The OSA is not a Federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. Each state will determine whether the OSA is required and when the assessment must be completed. For questions regarding completion of the OSA, please contact your State Agency.

A0300: Optional State Assessment

A0300. Optional State Assessment

Enter Code ☐ **A. Is this assessment for state payment purposes only?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Assessment type**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment
5. **Other payment** assessment

Item Rationale

- Allows for collection of data required for state payment reimbursement.

Coding Instructions for A0300, Optional State Assessment

- Enter the code identifying whether this is an optional payment assessment. This assessment is not required by CMS but may be required by your state.
- If the assessment is being completed for state-required payment purposes, complete items A0300A and A0300B.

Coding Instructions for A0300A, Is this assessment for state payment purposes only?

- Enter the value indicating whether your state requires this assessment for payment.

  0. No
  1. Yes

A0300: Optional State Assessment (cont.)

Coding Tips and Special Populations

- This assessment is optional, as it is not Federally required; however, it may be required by your state.
- For questions regarding completion of this assessment, please contact your State agency.
- This must be a standalone assessment (i.e., cannot be combined with any other type of assessment).
- The responses to the items in this assessment are used to calculate the case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes.
- If your state does not require this record for state payment purposes, enter a value of "0" (No). If your state requires this record for state payment purposes, enter a value of "1" (Yes) and proceed to item A0300B, Assessment Type.

Coding Instructions for A0300B, Assessment Type

- Enter the number corresponding to the reason for completing this state assessment.

1. Start of therapy assessment
2. End of therapy assessment
3. Both Start and End of therapy assessment
4. Change of therapy assessment
5. Other payment assessment

D0200: Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: ***"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 resident: *"About **how often** have you been bothered by this?"*

Read and show the resident 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*	☐	☐

Item Rationale

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 common in nursing homes and are often underdiagnosed and undertreated.

DEFINITION

9-ITEM PATIENT HEALTH QUESTIONNAIRE (PHQ-9©)

A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

D0200: Resident Mood Interview (PHQ-9©) (cont.)

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

1. Interview any resident when D0100 = 1.
2. Conduct the interview in a private setting.
3. If an interpreter is used during resident 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 resident's responses. Interpreters are people who translate oral or written language from one language to another.
4. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
5. Be sure the resident can hear you.
   - Residents with a 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. If you are administering the PHQ-9© in paper form, be sure that the resident can see the print. Provide large print or assistive device (e.g., page magnifier) if necessary.
7. 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 us provide you with better care."
8. Explain and /or show the interview response choices. A cue card with the response choices clearly written in large print might help the resident 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 2 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."

D0200: Resident Mood Interview (PHQ-9©) (cont.)

9. Interview the resident.

   Suggested language: "Over the last 2 weeks, have you been bothered by any of the following problems?"

   Then, for each question in **Resident Mood Interview** (D0200):

   - Read the item as it is written.
   - Do not provide definitions because the meaning **must be** based on the resident's interpretation. For example, the resident defines for themself what "tired" means; the item should be scored based on the resident'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 in Column 1 and leave Column 2 blank if the resident was unable or chose not to complete the assessment or responded nonsensically. A **nonsensical** response is one that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated (e.g., when asked the question about "poor appetite or overeating," the resident answers, "I always win at poker.").
   - For a **yes** response, ask the resident to tell you how often they were bothered by the symptom over the last 14 days. Use the response choices in D0200 Column 2, **Symptom Frequency**. Start by asking the resident the number of days that they were 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 resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
- **Code 1, yes:** if resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9, no response:** if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.
- Enter a Dash in Column 1 if the symptom presence was not assessed.

D0200: Resident Mood Interview (PHQ-9©) (cont.)

Coding Instructions for Column 2. Symptom Frequency

Record the resident's responses as they are stated, regardless of whether the resident 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 resident indicates that they have never or have only experienced the symptom on 1 day.
- **Code 1, 2-6 days (several days):** if the resident indicates that they have experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if the resident indicates that they have experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if the resident indicates that they have experienced the symptom for 12-14 days.

Coding Tips and Special Populations

- Attempt to conduct the interview with ALL residents.
- For question D0200I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
  - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the resident or may feel that the question is too personal. Others may worry that it will give the resident inappropriate ideas. However,
    - Experienced interviewers have found that most residents 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 resident is already feeling.
    - The best interviewing approach is to ask the question openly and without hesitation.
- If the resident uses their own words to describe a symptom, this should be briefly explored. If you determine that the resident is reporting the intended symptom but using their own words, ask them to tell you how often they were bothered by that symptom.
- Select only one frequency response per item.
- If the resident has difficulty selecting between two frequency responses, code for the higher frequency.
- Some items (e.g., item F) contain more than one phrase. If a resident gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Residents may respond to questions:
  - verbally,
  - by pointing to their answers on the cue card, OR
  - by writing out their answers.

D0200: Resident Mood Interview (PHQ-9©) (cont.)

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some residents 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…."
    - Validate your understanding of what the resident 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 resident 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 2 weeks?"
    - If the resident says "yes," show the cue card and ask whether it bothered them nearly every day (12-14 days) or on half or more of the days (7-11 days).
    - If the resident says "no," show the cue card and ask whether it bothered them several days (2-6 days) or never or 1 day (0-1 day).
- Noncommittal responses such as "not really" should be explored. Residents 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 D0200E, **Poor Appetite or Overeating**. The resident 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."
    - 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 2 weeks?"

D0200: Resident Mood Interview (PHQ-9©) (cont.)

- **Example:** Item D0200A, **Little Interest or Pleasure in Doing Things**. The resident, when asked how often they have 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 2 weeks, how often have you been bothered by little interest or pleasure in doing things."
- **Example:** Item D0200B, **Feeling Down, Depressed, or Hopeless**. The resident, when asked how often they have been bothered by feeling down, depressed, or hopeless, responds: "How would you feel if you were here?"
  - 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 2 weeks?"

- If the resident 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 a resident has moderate cognitive impairment but can respond to simple, direct questions.
  - **Example:** Item D0200E, Poor Appetite or Overeating.
    - You can simplify this item by asking: "In the last 2 weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?"
  - **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 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?"

D0300: Total Severity Score

D0300. Total Severity Score

Enter Score ☐☐ **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

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 resident'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.

DEFINITION

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.

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 **Resident Mood Interview** (D0200) Column 2.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.
3. The maximum resident score is 27 (3 x 9).

Coding Instructions

- The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©.
- If symptom frequency is blank for 3 or more items, the interview is deemed **NOT** complete. **Total Severity Score** should be coded as "99" and the **Staff 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 3 or more items).
- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see the PHQ-9© Resident Mood Interview Total Severity Score Scoring Rules following this section.

D0300: Total Severity Score (cont.)

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 9 items—5 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 9 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

PHQ-9© Scoring Rules: Resident Mood Interview Total Severity Score: D0300

- Item D0300 is used to store the total severity score for the Resident Mood Interview. The score in item D0300 is based upon the sum of the values that are contained in the following nine items: D0200A2, D0200B2, D0200C2, D0200D2, D0200E2, D0200F2, D0200G2, D0200H2, D0200I2. These are referred to as the "items in Column 2", below.
- The following rules explain how to compute the score that is placed in item D0300. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are either skipped or are equal to dash. An item in Column 2 could be skipped if the corresponding item in Column 1 was equal to 9 (no response). An item in Column 2 could be equal to dash if the item could not be assessed for some other reason (e.g., if the resident was unexpectedly discharged before the assessment could be completed).
- If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0300 is equal to the simple sum of those values.
- If any of the items in Column 2 are skipped or equal to dash, then omit their values when computing the sum.

PHQ-9© Scoring Rules: Resident Mood Interview Total Severity Score: D0300 (cont.)

- If the number of missing items in Column 2 is equal to **one**, then compute the simple sum of the eight items in Column 2 that have non-missing values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in item D0300.
- If the number of missing items in Column 2 is equal to **two,** then compute the simple sum of the seven items in Column 2 that have non-missing values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in item D0300.
- If the number of missing items in Column 2 is equal to **three or more but at least one of the items in Column 2 is not equal to dash,** then item D0300 must equal [99].

If all of the items in Column 2 are equal to dash, then enter dash in item D0300.

Example 1: All Items in Column 2 Have Non-missing Values

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

Item	Value
D0200A2	0
D0200B2	1
D0200C2	2
D0200D2	2
D0200E2	3
D0200F2	0
D0200G2	1
D0200H2	3
D0200I2	2
D0300	**14**

In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are skipped or equal to dash). Therefore, the value of D0300 is equal to the simple sum of the values in Column 2, which is 14.

PHQ-9© Scoring Rules: Resident Mood Interview Total Severity Score: D0300 (cont.)

Example 2: One Missing Value in Column 2

The following example shows how to score the resident interview when one of the items in Column 2 has a missing value:

Item	Value
D0200A2	0
D0200B2	1
D0200C2	2
D0200D2	2
D0200E2	—
D0200F2	0
D0200G2	1
D0200H2	3
D0200I2	2
D0300	**12**

In this example, one of the items in Column 2 (D0200E2) has a missing value (it is blank or skipped) and the other 8 items have non-missing values. D0300 is computed as follows:

1. Compute the sum of the 8 items with non-missing values. This sum is 11.
2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375.
3. Round the result to the nearest integer. In the example, 12.375 rounds to 12.
4. Place the rounded result in D0300.

PHQ-9© Scoring Rules: Resident Mood Interview Total Severity Score: D0300 (cont.)

Example 3: Two Missing Values in Column 2

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

Item	Value
D0200A2	0
D0200B2	1
D0200C2	2
D0200D2	2
D0200E2	—
D0200F2	0
D0200G2	1
D0200H2	—
D0200I2	2
D0300	**10**

In this example, two of the items in Column 2 have missing values: D0200E2 is blank or skipped, and D0200H2 is equal to dash. The other 7 items have non-missing values. D0300 is computed as follows:

1. Compute the sum of the 7 items with non-missing values. This sum is 8.
2. Multiply this sum by 1.286. In the example, 8 x 1.286 = 10.288.
3. Round the result to the nearest integer. In the example, 10.288 rounds to 10.
4. Place the rounded result in D0300.

PHQ-9© Scoring Rules: Resident Mood Interview Total Severity Score: D0300 (cont.)

Example 4: Three or More Missing Values in Column 2

The following example shows how to score the resident interview when three or more of the items in Column 2 have missing values and at least one of the values is not equal to dash:

Item	Value
D0200A2	0
D0200B2	1
D0200C2	2
D0200D2	2
D0200E2	—
D0200F2	—
D0200G2	1
D0200H2	—
D0200I2	2
D0300	**99**

In this example, three of the items in Column 2 have missing values: D0200E2 and D0200F2 are blank or skipped, and D0200H2 is equal to dash. The other 6 items have non-missing values and at least one of these items is not equal to dash. Because three or more items have missing values, D0300 is equal to 99.

Example 5: All Items in Column 2 Have Dashes

The following example shows how to score the resident interview when all of the items in Column 2 have dashes:

Item	Value
D0200A2	—
D0200B2	—
D0200C2	—
D0200D2	—
D0200E2	—
D0200F2	—
D0200G2	—
D0200H2	—
D0200I2	—
D0300	—

PHQ-9© Scoring Rules: Resident Mood Interview Total Severity Score: D0300 (cont.)

In this example, all of the items in Column 2 contain dashes. In this special case, enter a dash in D0300 (enter a single dash in the leftmost space of D0300 and leave the second space blank).

G0110: Activities of Daily Living (ADL) Assistance

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

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

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

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

Coding:

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

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Item Rationale

Health-related Quality of Life

- Almost all nursing home residents need some physical assistance. In addition, most are at risk of further physical decline. The amount of assistance needed and the risk of decline vary from resident to resident.
- 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 weakness, possible reversible causes such as de-conditioning, and adverse side effects of medications or other treatments. These may contribute to needless loss of self-sufficiency. In addition, some neurologic injuries such as stroke may continue to improve for months after an acute event.
- For some residents, cognitive deficits can limit ability or willingness to initiate or participate in self-care or restrict understanding of the tasks required to complete ADLs.
- A resident's potential for maximum function is often underestimated by family, staff, and the resident. Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident.
- Many residents might require lower levels of assistance if they are provided with appropriate devices and aids, assisted with segmenting tasks, or are given adequate time to complete the task while being provided graduated prompting and assistance. This type of supervision requires skill, time, and patience.

DEFINITIONS

ADL
Tasks related to personal care; any of the tasks listed in items G0110A, B, H and I.

ADL ASPECTS
Components of an ADL activity. These are listed next to the activity in the item set. For example, the components of G0110H (Eating) are eating, drinking, and intake of nourishment or hydration by other means, including tube feeding, total parenteral nutrition and IV fluids for hydration.

ADL SELF-PERFORMANCE
Measures what the resident actually did (not what they might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.
- Graduated prompting/task segmentation (helping the resident break tasks down into smaller components) and allowing the resident time to complete an activity can often increase functional independence.

DEFINITION

ADL SUPPORT PROVIDED
Measures the most support provided by staff over the last 7 days, even if that level of support only occurred once.

Steps for Assessment

1. Review the documentation in the medical record for the 7-day look-back period.
2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for themself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.
3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, observe what the resident is able to do without assistance, and then determine the level of assistance the resident requires from staff for moving to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

   To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See the **Example of a Probing Conversation with Staff** section below for an example of using probes when talking to staff.

Activities of Daily Living Definitions

A. Bed mobility: how resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture.

B. Transfer: how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet).

H. Eating: how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).

I. Toilet use: how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding Instructions

For each ADL activity:

- Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that they like), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).
- In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for themself, noting when assistance is received and clarifying the type (weight-bearing, non-weight-bearing, verbal cueing, guided maneuvering, etc.) and level of assistance (supervision, limited assistance, etc.) provided by all disciplines.
- If a resident uses special adaptive devices such as a walker for transfers or adaptive eating utensils, code ADL Self-Performance and ADL Support Provided based on the level of assistance the resident requires when using such items.
- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents.
- The ADL Self-Performance coding level definitions are intended to reflect real world situations where slight variations in level of ADL self-performance are common.
- To assist in coding ADL Self-Performance items, facilities may augment the instructions with the **ADL Self-Performance Rule of 3 Algorithm** below.
- This section involves a two-part ADL evaluation: Self-Performance, which measures how much of the ADL activity the resident can do for themself, and Support Provided, which measures how much facility staff support is needed for the resident to complete the ADL. Each of these sections uses its own scale; therefore, it is recommended that the ADL Self-Performance evaluation (Column 1) be completed for all ADL activities before beginning the ADL Support evaluation (Column 2).

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding Instructions for G0110, Column 1, ADL Self-Performance

- **Code 0, independent:** if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times.
- **Code 1, supervision:** if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days.
- **Code 2, limited assistance:** if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days.
- **Code 3, extensive assistance:** if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:
  - Weight-bearing support provided **three or more times, OR**
  - Full staff performance of activity **three or more times** during part but not all of the last 7 days.
- **Code 4, total dependence:** if there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- **Code 7, activity occurred only once or twice:** if the activity occurred **fewer than three times**.
- **Code 8, activity did not occur:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

The Rule of 3

- The "Rule of 3" is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.
- It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period.
- The following ADL Self-Performance coding levels are exceptions to the Rule of 3:
  - **Code 0, Independent** – Coded only if the resident completed the ADL activity with no help or oversight **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.
  - **Code 4, Total dependence –** Coded only if the resident required **full staff performance** of the ADL activity **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

— **Code 7, Activity occurred only once or twice** – Coded if the ADL activity occurred **fewer than three times** in the 7-day look back period.

— **Code 8, Activity did not occur –** Coded only if the ADL activity **did not occur** or **family and/or non-facility staff provided care 100% of the time** for that activity over the entire 7-day look-back period.

Instructions for the Rule of 3:

When an ADL activity has occurred **three or more times**, apply the steps of the Rule of 3 below **(keeping the ADL coding level definitions and the above exceptions in mind)** to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).

1. When an activity occurs **three or more times at any one level**, code that level.

2. When an activity occurs **three or more times at multiple levels, code the most dependent level that occurred three or more times**.

3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following:

    a. Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when **every** episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3).

    b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).

    c. When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code limited assistance (2).

If none of the above are met, code supervision.

ADL Self-Performance Rule of 3 Algorithm

START HERE – Review these instructions for Rule of 3 before using the algorithm. **Follow steps in sequence and stop at first level that applies. Start by counting the number of episodes at each ADL Self-Performance Level.**

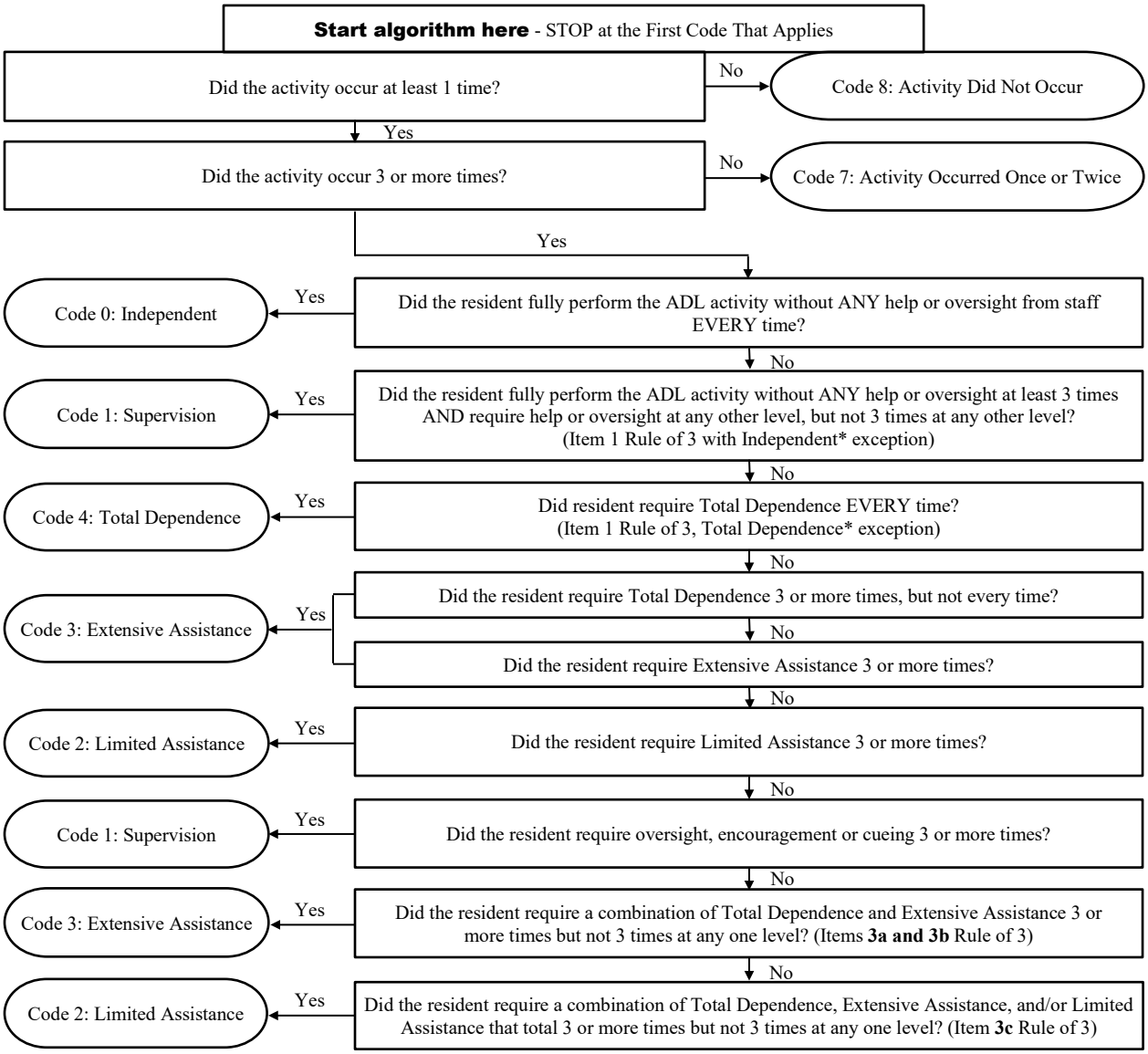
*** Exceptions to Rule of 3:**

- The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
- The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not occur at least 3 times.

Rule of 3:

1. When an activity occurs 3 or more times at any one level, code that level – *note exceptions for Independent (0) and Total Dependence (4).
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – *note exceptions for Independent (0) and Total Dependence (4).
3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed – stop at the first level that applies: (NOTE: This 3rd rule ***only*** applies if there are **NOT ANY LEVELS that are 3 or more episodes at any one level**. DO NOT proceed to 3a, 3b or 3c unless this criteria is met.)
   a. Convert episodes of Total Dependence (4) to Extensive Assistance (3).
   b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3).
   c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).

   If none of the above are met, code Supervision (1).



G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding Instructions for G0110, Column 2, ADL Support

*Code for the **most** support provided over all shifts. Code regardless of how Column 1 ADL Self-Performance is coded.*

- **Code 0, no setup or physical help from staff:** if resident completed activity with no help or oversight.
- **Code 1, setup help only:** if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- **Code 2, one person physical assist:** if the resident was assisted by one staff person.
- **Code 3, two+ person physical assist:** if the resident was assisted by two or more staff persons.
- **Code 8, ADL activity itself did not occur during the entire period:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Coding Tips and Special Populations

- Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility.
- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to their mouth, this is guided maneuvering.
- Do **NOT** record the staff's assessment of the resident's potential capability to perform the ADL activity.
- Do **NOT** record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened.
- Some residents are transferred between surfaces, including to and from the bed, chair, and wheelchair, by staff, using a full-body mechanical lift. Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as Extensive Assistance, as the resident participated in the transfer and the lift provided weight-bearing support.
- How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting.
- When a resident is transferred into or out of bed or a chair for incontinence care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use.
- Do **NOT** include assistance provided by family or other visitors.
- **Some examples for coding ADL Support Setup Help when the activity involves the following:**
  - Bed Mobility—handing the resident the bar on a trapeze, staff raises the ½ rails for the resident's use and then provides no further help.
  - Transfer—giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
  - Eating—cutting meat and opening containers at meals; giving one food item at a time.
  - Toilet Use—handing the resident a bedpan or placing articles necessary for changing an ostomy appliance within reach.
- **Supervision**
  - **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
  - General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.
- **Coding activity did not occur, 8:**
  - **Toileting** would be **coded 8, activity did not occur:** only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
  - **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.
- **Coding activity occurred only once or twice, 7:**
  - **Transfer** would be **coded 7, activity occurred only once or twice:** if the resident was on bed rest due to a terminal condition but transferred once from the bed to a recliner for a visit and then back to bed after the visit during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- **Residents with tube feeding, TPN, or IV fluids**
  - **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
  - **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, self-administer tube feeding, or actively participate with eating or drinking in any way).

Example of a Probing Conversation with Staff

1. Example of a probing conversation between the RN Assessment Coordinator and a nursing assistant (NA) regarding a resident's bed mobility assessment:

   RN: "Describe to me how Resident L. moves themself in bed. By that I mean once they are in bed, how do they move from sitting up to lying down, lying down to sitting up, turning side to side and positioning themself?"
   NA: "They can lay down and sit up by themself, but I help them turn on their side."
   RN: "They lay down and sit up without any verbal instructions or physical help?"
   NA: "No, I have to remind them to use their trapeze every time. But once I tell them how to do things, they can do it themself."
   RN: "How do you help them turn side to side?"
   NA: "They can help turn themself by grabbing onto their side rail. I tell them what to do. But they need me to lift their bottom and guide their legs into a good position."
   RN: "Do you lift them by yourself or does someone help you?"
   NA: "I do it by myself."
   RN: "How many times during the last 7 days did you give this type of help?"
   NA: "Every day, probably 3 times each day."

In this example, the assessor inquired specifically how Resident L. moves to and from a lying position, how they turn from side to side, and how the resident positions themself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect, so be sure to consider each activity definition fully. If the RN did not probe further, they would not have received enough information to make an accurate assessment of the actual assistance Resident. L. received. This information is important to know and document because accurate coding and supportive documentation provides the basis for reporting on the type and amount of care provided.

> **Coding:** Bed Mobility ADL assistance would be **coded 3 (self-performance) and 2 (support provided), extensive assistance with a one person assist.**

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110A, Bed Mobility

1. Resident D. can easily turn and position themself in bed and is able to sit up and lie down without any staff assistance at any time during the 7-day look-back period. They require use of a single side rail that staff place in the up position when they are in bed.

   Coding: G0110A1 would be **coded 0, independent**.
   G0110A2 would be **coded 1, setup help only**.

   Rationale: Resident is independent at all times in bed mobility during the 7-day look-back period and needs only setup help.

2. Resident favors lying on their right side. Because they have had a history of skin breakdown, staff must verbally remind them to reposition off their right side daily during the 7-day look-back period.

   Coding: G0110A1 would be **coded 1, supervision**.
   G0110A2 would be **coded 0, no setup or physical help from staff**.

   Rationale: Resident requires staff supervision, cueing, and reminders for repositioning more than three times during the look-back period.

3. Resident favors lying on their right side. Because they have had a history of skin breakdown, staff must sometimes cue the resident and guide (non-weight-bearing assistance) the resident to place their hands on the side rail and encourage them to change their position when in bed daily over the 7-day look-back period.

   Coding: G0110A1 would be **coded 2, limited assistance**.
   G0110A2 would be **coded 2, one person physical assist**.

   Rationale: Resident requires cueing and encouragement with setup and non-weight-bearing physical help daily during the 7-day look-back period.

4. Resident Q. has slid to the foot of the bed four times during the 7-day look-back period. Two staff members had to physically lift and reposition them toward the head of the bed. Resident Q. was able to assist by bending their knees and pushing with legs when reminded by staff.

   Coding: G0110A1 would be **coded 3, extensive assistance**.
   G0110A2 would be **coded 3, two+ persons physical assist**.

   Rationale: Resident required weight-bearing assistance of two staff members on four occasions during the 7-day look-back period with bed mobility.

5. Resident S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn them every 2 hours without any participation at any time from them at any time during the 7-day look-back period. They must be physically assisted to a seated position in bed when reading.

   Coding: G0110A1 would be **coded 4, total dependence**.
   G0110A2 would be **coded 3, two+ persons physical assist**.

   Rationale: Resident did not participate at any time during the 7-day look-back period and required two staff to position them in bed.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110B, Transfer

1. When transferring from bed to chair or chair back to bed, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk from the bed to chair and chair back to the bed every day during the 7-day look back period.

   Coding: G0110B1 would be **coded 0, independent**.
   G0110B2 would be **coded 0, no setup or physical help from staff**.

   Rationale: Resident is independent each and every time they transferred during the 7-day look-back period and required no setup or physical help from staff.

2. Staff must supervise the resident as they transfer from their bed to wheelchair daily. Staff must bring the chair next to the bed and then remind them to hold on to the chair and position their body slowly.

   Coding: G0110B1 would be **coded 1, supervision**.
   G0110B2 would be **coded 1, setup help only**.

   Rationale: Resident requires staff supervision, cueing, and reminders for safe transfer. This activity happened daily over the 7-day look-back period.

3. Resident H. is able to transfer from the bed to chair when they use their walker. Staff place the walker near their bed and then assist the resident with guided maneuvering as they transfer. The resident was noted to transfer from bed to chair six times during the 7-day look-back period.

   Coding: G0110B1 would be **coded 2, limited assistance**.
   G0110B2 would be **coded 2, one person physical assist**.

   Rationale: Resident requires staff to set up their walker and provide non-weight-bearing assistance when they are ready to transfer. The activity happened six times during the 7-day look-back period.

4. Resident B. requires weight-bearing assistance of one staff member to partially lift and support them when being transferred. The resident was noted to have been transferred 14 times in the 7-day look-back period and each time required weight-bearing assistance.

   Coding: G0110B1 would be **coded 3, extensive assistance**.
   G0110B2 would be **coded 2, one person physical assist**.

   Rationale: Resident partially participates in the task of transferring. The resident was noted to have transferred 14 times during the 7-day look-back period, each time requiring weight-bearing assistance of one staff member.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

5. Resident T. is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer them to a reclining chair daily using a mechanical lift. Resident T. is unable to assist or participate in any way.

   Coding: G0110B1 would be **coded 4, total dependence**.
   G0110B2 would be **coded 3, two+ persons physical assist**.

   Rationale: Resident did not participate and required two staff to transfer them out of their bed. The resident was transferred out of bed to the chair daily during the 7-day look-back period.

6. Resident D. is post-operative for extensive surgical procedures. Because of their ventilator dependent status in addition to multiple surgical sites, their physician has determined that they must remain on total bed rest. During the 7-day look-back period the resident was not moved from the bed.

   Coding: G0110B1 would be **coded 8, activity did not occur**.
   G0110B2 would be **coded 8, ADL activity itself did not occur during entire period**.

   Rationale: Activity did not occur.

7. Resident M. has Parkinson's disease and needs weight-bearing assistance of two staff to transfer from their bed to their wheelchair. During the 7-day look-back period, Resident M. was transferred once from the bed to the wheelchair and once from wheelchair to bed.

   Coding: G0110B1 would be **coded 7, activity occurred only once or twice**.
   G0110B2 would be **coded 3, two+ persons physical assist**.

   Rationale: The activity happened only twice during the look-back period, with the support of two staff members.

Examples for G0110H, Eating

1. After staff deliver Resident K.'s meal tray, they consume all food and fluids without any cueing or physical help during the entire 7-day look-back period.

   Coding: G0110H1 would be **coded 0, independent**.
   G0110H2 would be **coded 0, no setup or physical help from staff**.

   Rationale: Resident is completely independent in eating during the entire 7-day look-back period.

2. One staff member had to verbally cue the resident to eat slowly and drink throughout each meal during the 7-day look-back period.

   Coding: G0110H1 would be **coded 1, supervision**.
   G0110H2 would be **coded 0, no setup or physical help from staff**.

   Rationale: Resident required staff supervision, cueing, and reminders for safe meal completion daily during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

3. Resident V. is able to eat by themself. Staff must set up the tray, cut the meat, open containers, and hand them the utensils. Each day during the 7-day look-back period, Resident V. required more help during the evening meal, as they were tired and less interested in completing their meal. In the evening, in addition to encouraging the resident to eat and handing them their utensils and cups, staff must also guide the resident's hand so they will get the utensil to their mouth.

   Coding: G0110H1 would be **coded 2, limited assistance**.
   G0110H2 would be **coded 2, one person physical assist**.
   Rationale: Resident is unable to complete the evening meal without staff providing them non-weight-bearing assistance daily.

4. Resident F. begins eating each meal daily by themself. During the 7-day look-back period, after they had eaten only their bread, they stated they were tired and unable to complete the meal. One staff member physically supported their hand to bring the food to their mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

   Coding: G0110H1 would be **coded 3, extensive assistance**.
   G0110H2 would be **coded 2, one person physical assist**.
   Rationale: Resident partially participated in the task daily at each meal, but one staff member provided weight-bearing assistance with some portion of each meal.

5. Resident U. is severely cognitively impaired. They are unable to feed themself. They relied on one staff member for all nourishment during the 7-day look-back period.

   Coding: G0110H1 would be **coded 4, total dependence**.
   G0110H2 would be **coded 2, one person physical assist**.
   Rationale: Resident did not participate and required one staff person to feed them all of their meals during the 7-day look-back period.

6. Resident D. receives all of their nourishment via a gastrostomy tube. They did not consume any food or fluid by mouth. During the 7-day look-back period, they did not participate in the gastrostomy nourishment process.

   Coding: G0110H1 would be **coded 4, total dependence**.
   G0110H2 would be **coded 2, one person physical assist**.
   Rationale: During the 7-day look-back period, they did not participate in eating and/or receiving of their tube feed during the entire period. They required full staff performance of these functions.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110I, Toilet Use

1. Resident L. transferred themself to the toilet, adjusted their clothing, and performed the necessary personal hygiene after using the toilet without any staff assistance daily during the entire 7-day look-back period.

   Coding: G0110I1 would be **coded 0, independent**.
   G0110I2 would be **coded 0, no setup or physical help from staff**.
   Rationale: Resident was independent in all their toileting tasks.

2. Staff member must remind resident to toilet frequently during the day and to unzip and zip pants and to wash their hands after using the toilet. This occurred multiple times each day during the 7-day look-back period.

   Coding: G0110I1 would be **coded 1, supervision**.
   G0110I2 would be **coded 0, no setup or physical help from staff**.
   Rationale: Resident required staff supervision, cueing and reminders daily.

3. Staff must assist Resident P. to zip their pants, hand them a washcloth, and remind them to wash their hands after using the toilet daily. This occurred multiple times each day during the 7-day look-back period.

   Coding: G0110I1 would be **coded 2, limited assistance**.
   G0110I2 would be **coded 2, one person physical assist**.
   Rationale: Resident required staff to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

4. Resident M. has had recent bouts of vertigo. During the 7-day look-back period, the resident required one staff member to assist and provide weight-bearing support to them as they transferred to the bedside commode four times.

   Coding: G0110I1 would be **coded 3, extensive assistance**.
   G0110I2 would be **coded 2, one person physical assist**.
   Rationale: During the 7-day look-back period, the resident required weight-bearing assistance with the support of one staff member to use the commode four times.

5. Resident W. is cognitively and physically impaired. During the 7-day look-back period, they were on strict bed rest. Staff were unable to physically transfer them to toilet during this time. Resident W. is incontinent of both bowel and bladder. One staff member was required to provide all the care for their elimination and hygiene needs several times each day.

   Coding: G0110I1 would be **coded 4, total dependence**.
   G0110I2 would be **coded 2, one person physical assist**.
   Rationale: Resident did not participate and required one staff person to provide total care for toileting and hygiene each time during the entire 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Scenario Examples

1. **Scenario:** The following assistance was provided to Resident C. over the last seven days: Four times, they required verbal cueing for hand placement during stand-pivot transfers to their wheelchair and three times they required weight-bearing assistance to help them rise from the wheelchair, steady them and help them turn with their back to the edge of the bed. Once they were at the edge of the bed and put their hand on their transfer bar, they were able to sit. They completed the activity without assistance the 14 remaining instances during the 7-day look-back period. The four times that they required verbal cueing from the staff for hand placement are considered supervision. The three times that the staff had to physically support Resident C. during a portion of the transfer are considered weight-bearing assistance. This ADL occurred 21 times over the 7-day look-back period. There were three or more times where supervision was required, and three times where weight-bearing assistance was required; therefore, the appropriate code to enter on the MDS is Extensive assistance (3).

   Rationale: The ADL activity occurred 21 times over the 7-day look-back period. Resident C. required supervision four times and weight-bearing assistance was provided three times during the 7-day look-back period. The ADL activity also occurred three or more times at multiple levels (four times with supervision, three times with weight-bearing assistance, and 14 times without assistance). Weight-bearing assistance is also the highest level of dependence identified that occurred three or more times. The first Rule of 3 does not apply because the ADL activity occurred three or more times at multiple levels, not three or more times at any one level. Because the ADL activity occurred three or more times at multiple levels, the scenario meets the second Rule of 3 and the assessor will apply the most dependent level that occurred three or more times. Note that this scenario does meet the definition of Extensive assistance as well, since the activity occurred at least three times and there was weight-bearing support provided three times. The final code that should be entered in Column 1, ADL Self-Performance, G0110B – Transfer is Extensive assistance (3).

G0110: Activities of Daily Living (ADL) Assistance (cont.)

2. **Scenario:** Resident F. was in the nursing home for only one day prior to transferring to another facility. While there, they were unable to complete a component of the eating ADL activity without assistance three times. The following assistance was provided: Twice they required weight-bearing assistance to help lift their fork to their mouth. One time in the evening, the staff fed Resident F. because they could not scoop the food on their plate with the fork, nor could they lift the fork to their mouth. The three times that Resident F. could not complete the activity, the staff had to physically assist them by either holding their hand as they brought the fork to their mouth, or by actually feeding them. There were two times where the staff provided weight-bearing assistance and one time where they provided full staff performance. This component of the ADL eating activity where assistance was required, occurred three times in the look-back period, but not three times at any one level. Based on the third Rule of 3, the final code determination is Extensive assistance (3).

   Rationale: Eating occurred three times in the look-back period during the day that Resident F. was in the nursing home. Resident F. performed part of the activity by scooping the food and holding their fork two times, but staff had to assist by lifting their arm to their mouth resulting in two episodes of weight-bearing assistance. The other time, the staff had to feed Resident F. The first Rule of 3 does not apply because even though the ADL assistance occurred three or more times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three or more times it did not occur three or more times at multiple levels. The third Rule of 3 applies since the ADL assistance occurred three times at multiple levels but not three times at any one level. Sub-item "a" under the third Rule of 3 states to convert episodes of full staff performance to weight-bearing assistance as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. Therefore, the one episode of full staff performance is considered weight-bearing assistance and can be added to the other two episodes of weight-bearing assistance. This now totals three episodes of weight-bearing assistance. Therefore, according to the application of the third Rule of 3 and the first two sub-items, "a" and "b," the correct code to enter in Column 1, ADL Self-Performance, G0110H, Eating is Extensive assistance (3). Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3 and the first two sub-items that the facility is able to code this item as extensive assistance.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

3. **Scenario:** During the look-back period, Resident S. was able to toilet independently without assistance 18 times. The other two times toileting occurred during the 7-day look-back period, they required the assistance of staff to pull the zipper up on their pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision.

   Rationale: Toilet use occurred 20 times during the look-back period. Non-weight-bearing assistance was provided two times and 18 times the resident used the toilet independently. When the assessor began looking at the ADL Self-Performance coding level definitions, they determined that Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Since Resident S. did require assistance to complete the ADL two times, Code 0 does not apply. Code 7, Activity occurred only once or twice, did not apply to this scenario because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times. The assessor also determined that the assistance provided to the resident does not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period, and that the ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either. The assessor continued to apply the coding instructions, looking at the Rule of 3. The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice. The second Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur three times at multiple levels, and the third Rule of 3 does not apply because the ADL occurred three or more times, at the independent level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items. However, the final instruction to the provider is that when neither the Rule of 3 nor the ADL Self-Performance coding level definitions apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use, the code Supervision (1) was entered.

K0510: Nutritional Approaches

K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last **7 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐
Z. **None of the above**	☐	☐

Item Rationale

Health-related Quality of Life

- Nutritional approaches that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals.

Planning for Care

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

DEFINITIONS

PARENTERAL/IV FEEDING
Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., 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.

Steps for Assessment

- Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.

Coding Instructions for Column 1

- Check all nutritional approaches performed **prior** to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.

K0510: Nutritional Approaches (cont.)

Coding Instructions for Column 2

Check all nutritional approaches performed **after** admission/entry or reentry to the facility and within the 7-day look-back period.

Check all that apply. If none apply, check K0510Z, None of the above

- **K0510A,** parenteral/IV feeding
- **K0510B,** feeding tube – nasogastric or abdominal (PEG)
- **K0510Z,** none of the above

Coding Tips for K0510A

K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.

- Parenteral/IV feeding—The following fluids may be included **when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and Federal Regulations and/or internal facility policy:**
  - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
  - IV fluids running at KVO (Keep Vein Open)
  - IV fluids contained in IV Piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy
  - IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.
- **The following items are NOT to be coded in K0510A:**
  - IV Medications—**Code these when appropriate in O0100H, IV Medications.**
  - 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.

Coding Tip for K0510B

- Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0510B.

K0510: Nutritional Approaches (cont.)

Examples

1. Resident H. is receiving an antibiotic in 100 cc of normal saline via IV. They have a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth >100,000 colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. They are placed on the nursing home's hydration plan to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.

   Coding: K0510A would **be checked.** The IV medication would be coded at **IV Medications** item (O0100H).
   Rationale: The resident received 100 cc of IV fluid **and** there is supporting documentation that reflected an identified need for additional fluid intake for hydration.

2. Resident J. is receiving an antibiotic in 100 cc of normal saline via IV. They have a UTI, no fever, and documented adequate fluid intake. They are placed on the nursing home's hydration plan to ensure adequate hydration.

   Coding: K0510A would **NOT be checked.** The IV medication would be coded at **IV Medications** item (O0100H).
   Rationale: Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.

O0100: Special Treatments, Procedures, and Programs

Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident.**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ 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)	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	[redacted]	☐
None of the above		
Z. None of the above	☐	☐

Item Rationale

Health-related Quality of Life

- The treatments, procedures, and programs listed in Item O0100, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

O0100: Special Treatments, Procedures, and Programs (cont.)

Planning for Care

- Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.
- Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks.

Steps for Assessment

1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.

Coding Instructions for Column 1

Check all treatments, procedures, and programs received or performed by the resident **prior** to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, **check Z, none of the above**.

Coding Instructions for Column 2

Check all treatments, procedures, and programs received or performed by the resident **after** admission/entry or reentry to the facility and within the 14-day look-back period.

Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- **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, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the resident is not receiving the medication 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 the MDS. IVs, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O0100I (Transfusions).

O0100: Special Treatments, Procedures, and Programs (cont.)

Example: Resident J. was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After their cancer treatment, Resident 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 a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes their 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 resident performs their 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 resident performs their own tracheostomy care. This item includes laryngectomy tube care.

- **O0100F, Invasive Mechanical Ventilator (ventilator or respirator)**

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) **unable to support their own respiration** in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident 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: Resident 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 their own. O0100F should be checked, as Resident J. is using an invasive mechanical ventilator because they are unable to initiate spontaneous breathing on their own and the ventilator is controlling their breathing.

O0100: Special Treatments, Procedures, and Programs (cont.)

- **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. Lactated Ringers given IV is not considered a medication and should not be coded here. Resources and tools providing information on medications are available in Section N of the MDS *RAI 3.0 User's Manual* (see the end of the guidance for item N0415 following the Example).

- **O0100I, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **O0100J, Dialysis**

Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs their own dialysis.

- **O0100M, Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

O0100: Special Treatments, Procedures, and Programs (cont.)

Code for "single room isolation" only when all of the following conditions are met:

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

The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf

As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room isolation since it is still being maintained while the resident is in the facility.

Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. The definition and criteria of "significant change of status" is found in Chapter 2, Section 2.6, 03. Significant Change in Status Assessment (SCSA) (A0310A = 04). Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident's plan of care will likely need to be completed.

- **O0100Z, None of the above**

Code if none of the above treatments, procedures, or programs were received or performed by the resident.

O0450: Resumption of Therapy

O0450. Resumption of Therapy

A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?

Enter Code ☐

0. No
1. Yes

Item Rationale

In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. The EOT-R reduces the number of assessments that need to be completed and reduces the number of interview items residents must answer.

Coding Instructions

When an EOT OMRA has been performed, determine whether therapy will resume. If it will, determine whether therapy will resume no more than five consecutive calendar days after the last day of therapy was provided AND whether the therapy services will resume at the same level for each discipline. If No, **skip to O0500**, Restorative Nursing Programs. If Yes, **code item O0450A as 1**. For example:

- Resident A, who was in RVL, did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and they missed therapy on Monday because of a doctor's appointment. They resumed therapy on Tuesday, November 13, 2011. The IDT determined that their RUG-IV therapy classification level did not change as they had not had any significant clinical changes during the lapsed therapy days. When the EOT was filled out, item **O0450A was coded as 1** because therapy was resuming within 5 days from the last day of therapy and it was resuming at the same RUG-IV classification level.

NOTE: If the EOT OMRA has not been accepted in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system when therapy resumes, code the EOT-R item (O0450A) on the assessment and submit the record. If the EOT OMRA without the EOT-R item has been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the Resumption of Therapy item (O0450A) and check X0900Z and indicate that the reason for modification is the addition of the Resumption of Therapy item.

O0600: Physician Examinations

O0600. Physician Examinations

Enter Days

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

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 resident's health status.**

Steps for Assessment

1. **Review the physician progress notes for evidence of examinations of the resident by the physician or other authorized practitioners.**

Coding Instructions

- Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).
- If the State does not require the completion of this item, use the standard "no information" code (a dash, "**-**").

O0600: Physician Examinations (cont.)

Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
  - Chapter 15 of the ***Medicare Benefit Policy Manual*** (Pub. 100-2) and Chapter 12 of the ***Medicare Claims Processing Manual*** (Pub. 100-4) may be accessed at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.
- Does not include visits made by a medicine person, shaman, or other spiritual healer.

O0700: Physician Orders

O0700. Physician Orders

Enter Days

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Item Rationale

Health-related Quality of Life

- Health **status that** requires **frequent physician order changes can adversely affect an individual's sense of well-being and functional status and can limit social activities.**

Planning for Care

- Frequency **of** physician **order changes can be an indication of medical complexity and stability of the resident's health status.**

Steps for Assessment

1. **Review the physician order sheets in the medical record.**
2. **Determine the number of days during the 14-day look-back period that a physician or other authorized practitioner allowable by State law changed the resident's orders.**

Coding Instructions

- Enter the **number of days** during 14-day look-back period (or since admission, if less than 14 days ago) in which a physician changed the resident's orders.
- If the State does not require the completion of this item, use the standard "no information" code (a dash, "**-**").

Coding Tips and Special Populations

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, clinical nurse specialists, qualified dietitians, clinically qualified nutrition professionals or qualified therapists, working in collaboration with the physician as allowable by state law.
- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.

O0700: Physician Orders (cont.)

- Do not count orders prior to the date of admission or re-entry.
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does **not** constitute a new or changed order and may **not** be counted when coding this item.
- A Medicare Certification/Recertification is a renewal of an existing order and should **not** be included when coding this item.
- If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed.
- Orders written to increase the resident's RUG classification and facility payment are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.

X0570: Optional State Assessment (A0300A/B on existing record to be modified/inactivated)

X0570. Optional State Assessment (A0300A/B on existing record to be modified/inactivated)

Enter Code ☐

A. Is this assessment for state payment purposes only?
0. **No**
1. **Yes**

Enter Code ☐

B. Assessment type
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment
5. **Other payment** assessment

Item Rationale

- This item contains the reasons for assessment from the prior erroneous Optional State Assessment record to be modified/inactivated.

X0570: Optional State Assessment (A0300A/B on existing record to be modified/inactivated) (cont.)

Coding Instructions for X0570A, Is this assessment for state payment purposes only?

- Fill in the box with the state payment purpose code exactly as submitted for item A0300A "**Is this assessment for state payment purposes only?**" on the prior erroneous record to be modified/inactivated.
- Note that the state payment purpose code in X0570A must match the current value of A0300A on the modification request.

Coding Instructions for X0570B, Assessment Type

- Fill in the box with the assessment type code exactly as submitted for item A0300B "**Assessment Type**" on the prior erroneous record to be modified/inactivated.
- Note that the assessment type code in X0570B must match the current value of A0300B on the modification request.