

3.0 Medical Necessity and Level of Care Assessment

(MN/LOC)

Item by Item Guide

September 2019

3.0 Medical Necessity and Level of Care Item by Item Guide

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OVERVIEW TO THE 3.0 MN/LOC ITEM BY ITEM GUIDE

Overview

This guide is to be used in conjunction with the Medical Necessity and Level of Care Assessment (MN/LOC Assessment). A blank copy of the MN/LOC can be found [here](#). The MN/LOC Assessment includes the following sections:

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

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

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

considered when coding individual MN/LOC items.

- **Examples.** Case examples of appropriate coding for most MN/LOC sections/items.

Additional layout issues to note include:

- Resource Utilization Group (RUG) fields are identified with ®. In addition Appendix I lists all the RUG fields.
- Important definitions are included in each section.
- Pediatric Tips are included in each section as appropriate.
- All look-back periods are 7 days unless otherwise noted below the item.

Medical Necessity and Level of Care Assessment Purpose

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

- Supply current information that is used by medical professionals at Texas Medicaid & Healthcare Partnership (TMHP) to determine medical necessity (MN) for individuals. MN is the determination that an individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care. A determination that an individual meets MN is required for an individual to participate in CFC, MDCP, PACE, and SPW HCBS.
- Determine the Resource Utilization Group (RUG). A RUG is a systematic approach to categorize the care needs of an individual. The Texas Medicaid & Healthcare Partnership (TMHP) automated system uses a mathematical algorithm established by Centers for Medicare & Medicaid Services (CMS) to calculate a RUG value. This algorithm is used in all cases to automatically generate a RUG based on the information entered on the MN/LOC Assessment by the assessing nurse. The RUG is used to establish the service plan cost limit in MDCP and SPW HCBS.

RUG Training

RUG training must be completed every two years in order to complete and submit assessments. After training is completed, the nurse's license number is registered with the TMHP. License numbers associated with the assessment are verified to confirm training requirements have been met. The RUG training will be effective for a two-year period.

To enroll in the course, access the following website:

www.txstate.edu/continuinged

When to Complete and Submit an Assessment

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

- 1) Medical necessity; and 2) RUG

How to Complete and Submit an Assessment

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

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

Physician's Signature

A Physician's Signature page can be generated and printed from the TMHP LTC Online Portal for Initial, Annual, and Significant Change in Status Assessments. A physician's signature is required when submitting an Initial Assessment (when 01 is selected as the Reason for Assessment in Field A0310). *Initial Assessments cannot be submitted unless the physician has signed the statement on the Physician Signature Page* certifying the applicant requires Nursing Facility services or alternative community based services under the supervision of an MD/DO. A physician's signature is optional for Annual and Significant Change in Status Assessments.

Assessment Retention

Keep the electronic and/or handwritten assessment with appropriate original signatures in the individual's record in accordance with all applicable Department of Aging and Disability Services (DADS) record retention rules and your agency's policies.

Coding Conventions

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

- The standard look-back period for the MN/LOC 3.0 is 7 days, unless otherwise stated as in the following sections: D, I, J, K, O, and Long Term Care Medicaid Information (LTCMI).
- The Assessment Date (A2300) establishes the endpoint for all look-back periods.
- Responses entered on the LTMCI must not conflict with the responses entered on other sections of the MN/LOC Assessment.
- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another. This is called a skip pattern. When you encounter a skip pattern, leave the item blank and move on to the next item as directed (e.g., item B0100, **Comatose**, directs the assessor to skip to item G0110, **Activities of Daily**

Living Assistance, if B0100 is answered **code 1, yes**. The intervening items from B0200-F0800 would not be coded. If B0100 were recorded as **code 0, no**, then the assessor would continue with item B0200).

- Use a check mark for boxes where the instructions state to “check all that apply,” if specified condition is met; otherwise these boxes remain blank.
- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., D0350, **Safety Notification**).
- When recording month, day, and year for dates, enter two digits for the month and the day, and four digits for the year.
- Some MN/LOC 3.0 items allow a dash (-) value to be entered. A dash value indicates that an item was not assessed.
- **NONE OF ABOVE** is a response item to several items. Check this item where none of the responses apply; it should not be used to signify lack of information about the item.

SECTION A: IDENTIFICATION INFORMATION

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

A0310: Type of Assessment ®

A0310. Type of Assessment	
Enter <input type="text"/>	A. Reason for Assessment 01. Initial assessment 03. Annual assessment 04. Significant change in status assessment
Code <input type="text"/>	

Item Rationale

Allows identification of needed assessment content.

Coding Instructions for A0310, Type of Assessment

Enter the Reason for Assessment:

01. Initial Assessment- An Initial Assessment is completed when an individual is admitted to a Community Program. Please refer to the specific Community Program handbook or rules to determine if an MN/LOC must be completed for individuals transitioning from a Nursing Facility (NF) to a specific Community Program. In some instances, the MN and RUG determined by the Nursing Facility (NF) assessment (the Minimum Data Set [MDS]) may be valid for the Community Program. .
03. Annual Assessment- An Annual Assessment is required yearly. It must be submitted up to 90 days prior to the end of the service plan. Rejection of an Annual Assessment will occur if it is submitted more than 90 days prior to the service plan end date.
04. Significant Change in Status Assessment (SCSA) – For the purposes of this assessment process, a significant change is a decline in an individual’s condition that could potentially increase their current Resource Utilization Group (RUG) value. A SCSA does not apply for PACE. For MDCP and SPW refer to the program handbook to determine if a SCSA must be authorized prior to submission on the TMHP LTC Online Portal.

A0500: Legal Name of Individual

A0500. Legal Name of Individual			
	A. First name: <input type="text"/>		B. Middle initial: <input type="text"/>
	C. Last name: <input type="text"/>		D. Suffix: <input type="text"/>

Definitions

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

Item Rationale

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

Steps for Assessment

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

Coding Instructions

Use printed letters. Enter in the following order:

- A. First Name
- B. Middle Initial (if the individual has no middle initial, leave Item A0500B blank; if the individual has two or more middle names, use the initial of the first middle name)
- C. Last Name
- D. Suffix (e.g., Jr./Sr.)

A0600: Social Security and Medicare Numbers

A0600. Social Security and Medicare Numbers	
A. Social Security Number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
B. Medicare number (or comparable railroad insurance number):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Definitions

Social Security Number- A tracking number assigned to an individual by the U.S. federal government for taxation, benefits, and identification purposes.

Medicare Number (or comparable Railroad Insurance Number) - An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier may be different from an individual's social security number (SSN), and may contain both letters and numbers. For example, many individuals may receive Medicare benefits based on a spouse's Medicare eligibility.

Item Rationale

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

Coding Instructions

A0600A or A0600B is required but not both.

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

Coding Tips and Special Populations

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

A0700: Medicaid Number

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient												

Item Rationale

- Assists in correct identification.

Coding Instructions

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

Coding Tips and Special Populations

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

A0800: Gender

A0800. Gender	
Enter Code <input type="checkbox"/>	1. Male 2. Female

Item Rationale

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

Coding Instructions

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

Coding Tips and Special Populations

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

A0900: Birth Date

A0900. Birth Date	
<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Month Day Year

Item Rationale

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

Coding Instructions

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

A1000: Race/Ethnicity

A1000. Race/Ethnicity	
↓ Check all that apply	
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

Item Rationale

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

Steps for Assessment: Interview Instructions

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

Coding Instructions

Check all that apply.

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

A1100: Language

A1100. Language	
Enter <input type="checkbox"/> Code	A. Does the individual need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes → Specify in A1100B, Preferred language 9. Unable to determine B. Preferred language: <input type="text"/>

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

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

A1300: Optional Individual Items

A1300. Optional Individual Items	
B. Room number:	<input type="text"/>

Item Rationale

- This is an optional item.

Coding Instructions for A1300B, Room Number

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

A1550: Conditions Related to Intellectual and Developmental Disability Status

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

Definition

IDD – IDD is the acronym for Intellectual and Developmental Disability, formerly known as mental retardation (MR).

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

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

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

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

Item Rationale

- To document conditions associated with IDD.

Steps for Assessment

1. If individual is 22 years of age or older on the assessment date, complete only if A0310A =

01 (Initial Assessment).

2. If individual is 21 years of age or younger on the assessment date, always complete.

Coding Instructions

- Check all conditions related to IDD status that was present before age 22.
- When the ages of onsets are not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.
- **Code A:** if Down syndrome is present.
- **Code B:** if autism is present.
- **Code C:** if epilepsy is present.
- **Code D:** if other organic condition related to IDD is present.
- **Code E:** if an IDD condition is present but the individual does not have any of the specific conditions listed.
- **Code Z:** if no IDD is present.

A2300: Assessment Date

A2300. Assessment Date													
	Observation end date: <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Month</td><td>Day</td><td colspan="4">Year</td></tr></table>							Month	Day	Year			
Month	Day	Year											

Item Rationale

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

Steps for Assessment

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

Coding Instructions

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

SECTION B: HEARING, SPEECH, AND VISION

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

B0100: Comatose ®

B0100. Comatose	
Enter Code <input type="checkbox"/>	Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance

Definitions

Comatose (Coma) – A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain)

Persistent Vegetative State – Sometimes individuals, who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

Coding Tips

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

B0200: Hearing

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

televisions or radios. A noisy environment can inhibit opportunities for effective communication.

Steps for Assessment

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

Coding Instructions

- **Code 0, adequate:** No difficulty in normal conversation, social interaction or listening to TV. The individual hears all normal conversational speech and telephone conversation.
- **Code 1, minimal difficulty:** Difficulty in some environments (e.g., when a person speaks softly or the setting is noisy). The individual hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations. The individual's hearing is adequate after environmental adjustments are made, such as reducing background noise by moving to a quiet room or by lowering the volume on television or radio.
- **Code 2, moderate difficulty:** Speaker has to increase volume and speak distinctly. Although hearing-deficient, the individual compensates when the speaker adjusts tonal quality and speaks distinctly; or the individual can hear only when the speaker's face is clearly visible.
- **Code 3, highly impaired:** Absence of useful hearing. The individual hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Coding Tips for Special Populations

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

Pediatric Tips:

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

B0300: Hearing Aid

B0300. Hearing Aid	
Enter Code	Hearing aid or other hearing appliance used in completing B0200, Hearing
<input type="checkbox"/>	0. No
	1. Yes

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

B0600: Speech Clarity

B0600. Speech Clarity	
Enter Code <input type="checkbox"/>	Select best description of speech pattern 0. Clear speech - distinct intelligible words 1. Unclear speech - slurred or mumbled words 2. No speech - absence of spoken words

Definitions

Speech – The verbal expression of articulate words

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

Pediatric Tip:

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

B0700: Makes Self Understood ®

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

Definitions

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

1. Assess using the individual's preferred language.
2. Interact with the individual. Be sure he or she can hear you or have access to his or her preferred method for communication. If the individual seems unable to communicate, offer alternatives such as writing, pointing or using cue cards.

3. Observe his or her interactions with others in different settings and circumstances.
4. Consult with the primary caregiver and the individual's speech-language pathologist (if applicable).

Coding Instructions

- **Code 0, understood:** if the individual expresses requests and ideas clearly.
- **Code 1, usually understood:** if the individual has difficulty communicating some words or finishing thoughts but is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self-understood.
- **Code 2, sometimes understood:** if the individual has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, and toilet).
- **Code 3, rarely or never understood:** if, at best, the individual's understanding is limited to interpretation by caregivers of highly individualized, specific sounds or body language (e.g., indicated presence of pain or need to toilet).

Pediatric Tip:

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

B0799 Modes of Expression

B0799. Modes of Expression	
	Check all used by individual to make needs known
<input type="checkbox"/>	A. Speech
<input type="checkbox"/>	B. Writing messages to express or clarify needs
<input type="checkbox"/>	C. American sign language or Braille
<input type="checkbox"/>	D. Signs/ Gestures/ Sounds
<input type="checkbox"/>	E. Communication Board
<input type="checkbox"/>	F. Voice Modulator
<input type="checkbox"/>	G. Other
<input type="checkbox"/>	Z. None of the above

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

Coding Instructions

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

A. Speech

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

C. American Sign Language or Braille

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

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

F. Voice Modulator- An assistive listening device

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

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

B0800: Ability to Understand Others

B0800. Ability To Understand Others	
Enter <input type="checkbox"/> Code	Understanding verbal content, however able (with hearing aid or device if used). Enter '-' Dash if unable to assess. 0. Understands – clear comprehension 1. Usually understands – misses some part/intent of message but comprehends most conversation 2. Sometimes understands – responds adequately to simple, direct communication only 3. Rarely/never understands

Definitions

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

- **Code 0, understands:** if the individual clearly comprehends the message(s) and demonstrates comprehension by words or actions/behaviors.
- **Code 1, usually understands:** if the individual misses some part or intent of the message **but** comprehends most of it. The individual may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- **Code 2, sometimes understands:** if the individual demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or instructions. When rephrased or simplified the message(s) comprehension is enhanced.
- **Code 3, rarely/never understands:** if the individual demonstrates very limited ability to understand communication; if there is difficulty determining whether or not the individual comprehends messages based on verbal and nonverbal responses; if the individual can hear sounds but does not understand messages.
- **Code “-“Dash,** if unable to assess.

Pediatric Tip:

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

B1000: Vision

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

Definitions

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

1. Ask the caregiver about the individual's usual vision patterns during the 7-day look-back period (e.g., is the individual able to see newsprint, menus, and greeting cards)?
2. Ask the individual about his or her visual abilities.
3. Test the accuracy of your findings:
 - Ensure that the individual's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass).
 - Ensure adequate lighting.
 - Ask the individual to look at regular-size print in a book or newspaper. Then ask the individual to read aloud, starting with larger headlines and ending with the finest, smallest print. If the individual is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.

Coding Instructions

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

Coding Tips and Special Populations

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

Pediatric Tips:

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

B1200: Corrective Lenses

B1200. Corrective Lenses	
Enter Code	Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
<input type="checkbox"/>	0. No
<input type="checkbox"/>	1. Yes

Item Rationale

Health-related Quality of Life

- Decreased ability to see can limit the enjoyment of everyday activities and can contribute to

social isolation and mood and behavior disorders.

- Many individuals who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient.

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

SECTION C: COGNITIVE PATTERNS

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

C0100: Should Brief Interview for Mental Status Be Conducted?

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? – Attempt to conduct interview with the individual

Enter Code

0. No (individual is rarely/never understood) OR individual is less than 7 years of age, skip to and complete C0700-C1000, Caregiver Assessment for Mental Status

1. Yes → Continue to C0200, Repetition of Three Words

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

- **Code 0, no:**
 - If the interview should not be attempted because the individual is rarely/never understood (B0700 = 3) verbally or in writing,
 - an interpreter is needed but not available, or
 - If the individual is less than 7 years old. Skip to **Caregiver Assessment of Mental Status**.
- **Code 1, yes:**
 - If the interview should be attempted because the individual is at least sometimes understood verbally or in writing (B0700 = 0, 1, or 2), and
 - If an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

Coding Tip

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

Pediatric Tip

If the child is less than 7 years old skip to C0600. If the child is 7 years old or greater, use nursing judgment to determine whether to complete this section or skip to **Caregiver Assessment of Mental Status**.

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

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter <input type="text"/> Code	Ask individual: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words." Enter '-' Dash if unable to assess. Number of words repeated after first attempt 0. None 1. One 2. Two 3. Three After the individual's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.
C0300. Temporal Orientation (orientation to year, month, and day)	
Enter <input type="text"/> Code	Ask individual: "Please tell me what year it is right now." Enter '-' Dash if unable to assess. A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct
Enter <input type="text"/> Code	Ask individual: "What month are we in right now?" Enter '-' Dash if unable to assess. B. Able to report correct month 0. Missed by >1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter <input type="text"/> Code	Ask individual: "What day of the week is today?" Enter '-' Dash if unable to assess. C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct
C0400. Recall	
Enter <input type="text"/> Code	Ask individual: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. Enter '-' Dash if unable to assess. A. Able to recall "sock" 0. No – could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter <input type="text"/> Code	B. Able to recall "blue" 0. No – could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required
Enter <input type="text"/> Code	C. Able to recall "bed" 0. No – could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required
C0500. Summary Score	
Enter Score <input type="text"/>	The sum of the scores for questions C0200–C0400. The sum should be a number (00–15) A score of 99 indicates that the individual was unable to complete one or more questions of the interview

Definitions

Nonsensical Response – Any response that is unrelated, incomprehensible, or incoherent, it is not informative with respect to the item being rated.

Category Cue – Phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the individual. The category cue for sock is "something to wear." The category cue for blue is "a color." For bed, the category cue is "a piece of furniture."

Temporal Orientation – In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings.

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

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

1. Interview any individual not screened out by **Should Brief Interview for Mental Status Be Conducted?** item (C0100).
2. Conduct the interview in a private setting.
3. Be sure the individual can hear you.
 - Individuals with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
 - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
 - Minimize background noise.
4. Sit so that the individual can see your face. Minimize glare by directing light sources away from the individual's face.

5. Give an introduction before starting the interview.
Suggested language: “I would like to ask you some questions. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult.”
6. If the individual expresses concern that you are testing his or her memory, he or she may be more comfortable if you reply: “We ask these questions of everyone so we can make sure that care will meet your needs.”
7. Directly ask the individual each item in C0200 through C0400 at one sitting and in the order provided.
8. If the individual chooses not to answer a particular item, accept his or her refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect.
9. On occasion, the interviewer may not be able to state the words clearly because of an accent or slurred speech. If the interviewer is unable to pronounce any of the three recall words in C0200 clearly, have a different interviewer complete this section.
10. When the individual’s primary method of communication is in written format, the BIMS can be administered in writing. The administration of the BIMS in writing should be limited to this circumstance.

Coding Tips

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

Examples of Incorrect and Nonsensical Responses

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

Coding: This answer is **coded 0** but would NOT be considered a nonsensical response.

Rationale: The answer is wrong, but it is logical and relates to the question.

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

Coding: This answer is **coded 0** but would NOT be considered a nonsensical response.

Rationale: The answer is wrong because refusal is considered a wrong answer, but the individual’s comment is logical and clearly relates to the question.

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

Coding: The answer is **coded 0**; the response is illogical and nonsensical.

Rationale: The answer is wrong, and her comment clearly does not relate to the question; it is nonsensical.

C0200: Repetition of Three Words

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter <input type="text"/> Code	Ask individual: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: <i>sock, blue, and bed</i> . Now tell me the three words." Enter '-' Dash if unable to assess. Number of words repeated after first attempt 0. None 1. One 2. Two 3. Three After the individual's first attempt, repeat the words using cues (" <i>sock, something to wear; blue, a color; bed, a piece of furniture</i> "). You may repeat the words up to two more times.

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

*Record the maximum number of words that the individual correctly repeated on the **first** attempt. This will be any number between 0 and 3.*

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

Coding Tip

On occasion, the interviewer may not be able to state the words clearly because of an accent. If the interviewer is unable to pronounce any of the 3 words clearly, have a different interviewer conduct the interview.

Examples

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

Coding: C0200 would be **coded 3, three** words correct.

Rationale: He repeated all three items on the first attempt. The order of repetition does not affect the score.

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

Coding: C0200 would be **coded 2, two** of three words correct.

Rationale: She repeated two of the three items on the first attempt. Individuals are scored based on the first attempt.

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

Coding: C0200 would be **coded 2, two** of the three words correct.

Rationale: Mr. L repeated two of the three items—blue and sock. He put the words into a sentence, resulting in repeating two of the three words.

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

Coding: C0200 would be **coded 0, none** of the words correct.

Rationale: She did not repeat any of the three words after the first time the interviewer said them.

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

C0300. Temporal Orientation (orientation to year, month, and day)	
Enter <input type="checkbox"/> Code	Ask individual: "Please tell me what year it is right now." Enter '-' Dash if unable to assess. A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2–5 years 2. Missed by 1 year 3. Correct
Enter <input type="checkbox"/> Code	Ask individual: "What month are we in right now?" Enter '-' Dash if unable to assess. B. Able to report correct month 0. Missed by >1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter <input type="checkbox"/> Code	Ask individual: "What day of the week is today?" Enter '-' Dash if unable to assess. C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions for C0300A, Able to Report Correct Year

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

- **Code 2, missed by 1 year:** if the individual’s answer is incorrect and is within one year from the current year.
- **Code 3, correct:** if the individual states the correct year.

Examples

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

Coding: C0300A would be **coded 3, correct.**

Rationale: 2012 is the current year.

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

Coding: C0300A would be **coded 1, missed by 2-5 years.**

Rationale: 2009 is within 2 to 5 years of 2012.

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

Coding: C0300A would be **coded 0, missed by more than 5 years.**

Rationale: Even though the ‘12 part of the year would be correct, 1912 is more than 5 years from 2012.

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

Coding: C0300A would be **coded 3, correct.**

Rationale: Even though ‘12 is partially correct, the only correct answer is the exact year. She must state “2012,” not “’12” or “1812” or “1912.”

Coding Instructions for C0300B, Able to Report Correct Month

For C0200-C0400, also refer to Coding Instructions and Coding Tips for C0500 Summary Score

Count the current day as day one when determining whether the response was accurate within five days or missed by six days to one month.

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

Coding Tip

In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the individual's response in the margin and go back later to count days if you are unsure whether the date given is within 5 days.

Examples

1. The date of interview is June 25, 2012. Mr. A, responding to the question, "What month are we in right now?" states that it is June.

Coding: C0300B would be **coded 2, accurate within 5 days.**

Rationale: He correctly stated the month.

2. The date of interview is June 28, 2012 Ms. X, responding to the question, "What month are we in right now?" states that it is July.

Coding: C0300B would be **coded 2, accurate within 5 days.**

Rationale: She correctly stated the month within 5 days, even though the correct month is June. June 28th (day 1) + 4 more days is July 2nd, so July is within 5 days of the interview.

3. The date of interview is June 25, 2012. Mr. V, responding to the question, "What month are we in right now?" states that it is July.

Coding: C0300B would be **coded 1, missed by 6 days to 1 month.**

Rationale: He missed the correct month by six days. June 25th (day 1) + 5 more days = June 30th. Therefore, his answer is incorrect within 6 days to 1 month.

4. The date of interview is June 30, 2012. Ms. Q, responding to the question, "What month are we in right now?" states that it is August.

Coding: C0300B would be **coded 0, missed by more than 1 month.**

Rationale: She missed the month by more than 1 month.

5. The date of interview is June 2, 2012. Ms. S, responding to the question, "What month are we in right now?" states that it is May.

Coding: C0300B would be **coded 2, accurate within 5 days.**

Rationale: June 2 minus 5 days = May 29th. She correctly stated the month within 5 days even though the current month is June.

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

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

Examples

1. The day of interview is Monday, June 21, 2012. The interviewer asks: “What day of the week is it today?” Ms. N responds, “It’s Monday.”

Coding: C0300C would be **coded 1, correct.**

Rationale: She correctly stated the day of the week.

2. The day of interview is Monday, June 21, 2012. Mr. F, responding to the question, “What day of the week is it today?” states, “Tuesday.”

Coding: C0300C would be **coded 0, incorrect.**

Rationale: He incorrectly stated the day of the week.

3. The day of interview is Monday, June 21, 2012. Ms. D, responding to the question, “What day of the week is it today?” states, “Today is a good day.”

Coding: C0300C would be **coded 0, incorrect.**

Rationale: She did not answer the question correctly.

Pediatric Tip:

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

C0400: Recall

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

1. Ask the individual the following: “Let’s go back to an earlier question. What were those three words that I asked you to repeat?”
2. Allow up to 5 seconds for spontaneous recall of each word.
3. For any word that is not correctly recalled after 5 seconds, provide a category cue (refer to “Steps for Assessment,” for the definition of category cue). Category cues should be used only after the individual is unable to recall one or more of the three words.
4. Allow up to 5 seconds after category cueing for each missed word to be recalled.

Coding Instructions

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

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

Coding Tips

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

Examples

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

Coding: C0400A-C0400C would be **coded 0, no—could not recall**, could not recall for each of the three words.

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

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

Coding: C0400A, sock, would be **coded 2, yes, no cue required.**

Rationale: Mrs. C’s initial response to the question included “sock.” She is given credit for this response, even though she also listed another item in that category (shoes), because she was answering the initial question, without cueing.

Coding: C0400B, blue, would be **coded 1, yes, after cueing.**

Rationale: Mrs. C did not recall spontaneously, but did recall after the category cue was given. Responses that include the word in a sentence are acceptable.

Coding: C0400C, bed, would be **coded 2, yes, no cue required.**

Rationale: Mrs. C independently recalled the item on the first attempt.

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

Coding: C0400A, sock, would be **coded 0, no—could not recall.**

Rationale: She did not recall the item, even with a cue.

Coding: C0400B, blue, would be **coded 1, yes, after cueing.**

Rationale: She did recall after being given the cue.

Coding: C0400C, bed, would be **coded 0, no—could not recall.**

Rationale: She did not recall the item, even with a cue.

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

Coding: C0400A, sock, would be **coded 0, no—could not recall.**

Rationale: After getting the category cue, Mr. D named more than one item (i.e., a laundry list of items) in the category. His response is coded as incorrect, even though one of the items was correct, because he did not demonstrate recall and likely named the item by chance.

C0500: BIMS Summary Score ®

C0500. BIMS Summary Score

<input type="text"/>	<input type="text"/>
Enter Score	

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

Item Rationale

Health-related Quality of Life

- The total score:
 - Allows comparison with future and past performance.
 - Decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
 - Provides caregiver with a more reliable estimate of individual function and allows caregiver interactions with individuals that are based on more accurate impressions about individual ability.

Planning for Care

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

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

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

Step for Assessment

After completing C0200-C0400:

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

Coding Instructions

The total possible BIMS score ranges from 00 to 15

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

Coding Tips

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

Example

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

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

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

C0600. Should the Caregiver Assessment for Mental Status (C0700-C1000) be Conducted?	
Enter <input type="checkbox"/>	0. No (Individual was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
Code	1. Yes (Individual was unable to complete interview OR individual is less than 7 years of age) → Continue to C0700, Short-term Memory OK

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Step for Assessment

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

Coding Instructions

- **Code 0, no:** if the BIMS was completed and scored between 00 and 15. Skip to C1310.
- **Code 1, yes:** if the individual chooses not to participate in the BIMS or if four or more items were coded 0 because chose not to answer or gave a nonsensical response resulting in a score of 99. Also code 1, yes if the individual is less than 7 years of age. Continue to C0700-C1000 to perform the Caregiver Assessment for Mental Status.

Coding Tip

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

C0700-C1000: Caregiver Assessment of Mental Status Item

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
- The level and specific areas of impairment affect daily function and care needs. By identifying specific aspects of cognitive impairment, caregiver interventions can be directed toward facilitating greater function.
- Probing beyond first, perhaps mistaken, impressions is critical to accurate assessment and appropriate plan of care.

C0700: Short-term Memory OK ®

C0700. Short-term Memory OK	
Enter <input type="checkbox"/>	Seems or appears to recall after 5 minutes. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.
Code	0. Memory OK 1. Memory problem

Item Rationale

Health-related Quality of Life

- To assess the mental state of individuals who cannot be interviewed, an intact 5-minute recall (“short-term memory OK”) indicates greater likelihood of normal cognition.
- An observed “memory problem” should be taken into consideration in Planning for Care.

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

- **Code 0, memory OK:** if the individual recalled information after 5 minutes.
- **Code 1, memory problem:** if the most representative level of function shows the absence of recall after 5 minutes.
- **Code “-”, Dash:** if unable to assess or if the individual is less than 2 years of age.

Coding Tip

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

Example

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

Coding: C0700 would be **coded 1, memory problem.**

Rationale: Ms. G could not recall an event that took place within the past 5 minutes.

Pediatric Tip:

- This field is dashable. A dash means no information, or unable to assess/determine.
- If the child is less than 2 years old code this with a dash; do not ask the parent/caregiver. For a child 2 years old or greater, use nursing judgment to determine whether to ask the caregiver about the child's short-term memory, or code as a dash.

C0800: Long-term Memory OK

C0800. Long-term Memory OK	
Enter <input type="text"/>	Seems or appears to recall long past. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.
Code	0. Memory OK 1. Memory problem

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

- **Code 0, memory OK:** if the individual accurately recalled long past information.
- **Code 1, memory problem:** if the individual did not recall long past information or did not recall it correctly.
- **Code "--", Dash:** if unable to assess or if the individual is less than 2 years of age.

Coding Tip

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

Pediatric Tip:

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

C0900: Memory/Recall Ability

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

- An observed “memory/recall problem” with these items may indicate the need for:
 - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect; or
 - Possible evaluation for other problems with thinking
 - Additional signs, directions, pictures, verbal reminders to support the individual’s independence,
 - An evaluation for acute delirium if this represents a change over the past few days to weeks,
 - An evaluation for chronic delirium if this represents a change over the past several weeks to months,
 - Additional caregiver support; or
 - The need for emotional support, reminders and reassurance to reduce anxiety and agitation.

Steps for Assessment

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

Coding Instructions

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

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

C1000: Cognitive Skills for Daily Decision Making ®

C1000. Cognitive Skills for Daily Decision Making	
Enter Code <input type="checkbox"/>	Made decisions regarding tasks of daily life 0. Independent - decisions consistent/reasonable 1. Modified independence - some difficulty in new situations only 2. Moderately impaired - decisions poor; cues/supervision required 3. Severely impaired - never/rarely made decisions

Definitions

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

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

Coding Tips

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

Examples

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

Coding: For the examples listed in 1A and 1B, Item C1000 would be **coded 3, severe impairment.**

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

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

Coding: C1000 would be **coded 0, independent.**

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

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

Coding: C1000 would be **coded 1, modified independent.**

Rationale: The individual is independent under routine circumstances. However, when the situation was new or different, she had difficulty adjusting.

5. Mr. G. enjoys meals with his family members. Recently, he has started to lose weight. He appears to have little appetite, rarely eats without reminders and willingly gives his food to others at the table. Mr. G. requires frequent cueing from his caregiver to eat and supervision to prevent him from sharing his food.

Coding: C1000 would be **coded 2, moderately impaired.**

Rationale: Mr. G is making poor decisions by giving his food away. He requires cueing to eat and supervision to be sure that he is eating the food on his plate.

Pediatric Tip:

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

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

Delirium	
C1310. Signs and Symptoms of Delirium (from CAM©)	
Code after completing Brief Interview for Mental Status or Caregiver Assessment, and reviewing medical record	
A. Acute Onset Mental Status Change	
Enter Code <input type="checkbox"/>	Is there evidence of an acute change in mental status from the individual's baseline?" 0. No 1. Yes
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	↓ Enter Codes in Boxes
	<input type="checkbox"/> B. Inattention - Did the individual have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/> C. Disorganized Thinking - Was the individual's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="checkbox"/> D. Altered Level of Consciousness - Did the individual have altered level of consciousness, as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ vigilant - startled easily to any sound or touch ▪ lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ stuporous - very difficult to arouse and keep aroused for the interview ▪ comatose - could not be aroused
Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.	

Definitions

Delirium – A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

Inattention – Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Individual seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).

Fluctuation – The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look-back period. Fluctuating behavior may be noted by the interviewer, reported by the caregiver or family or documented in the medical record.

Disorganized Thinking – Evidenced by rambling, irrelevant, or incoherent speech.

Altered Level of Consciousness –

- **Vigilant** – startles easily to any sound or touch.
- **Lethargic** – repeatedly dozes off when you are asking questions, but responds to voice or touch.
- **Stupor** – very difficult to arouse and keep aroused for the interview.
- **Comatose** – cannot be aroused despite shaking and shouting.

Item Rationale

Health-related Quality of Life

- Delirium is associated with:
 - increased mortality,
 - functional decline,
 - development or worsening of incontinence,
 - behavior problems,
 - withdrawal from activities, and/or
 - re-hospitalizations and increased length of nursing facility stay.
- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.

Planning for Care

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

Steps for Assessment

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

Coding Instructions for C1310A, Acute Mental Status Change

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

Examples

1. Nurse is completing an initial assessment for Mr. S. His family reports that there has been a change and that just four days ago he was alert and oriented. During the BIMS interview, Mr. S is lethargic and incoherent.

Coding: C1310A would be **coded 1, yes**

Rationale: There is an acute change in the individual's behavior from alert and oriented (family report) to lethargic and incoherent during interview.

2. Mrs. G has poor short-term memory and disorientation to time. She suddenly becomes agitated, calling out to her dead husband, tearing off her clothes, and being completely disoriented to time, person, and place.

Coding: C1310A would be **coded 1, yes**

Rationale: The new behaviors represent an acute change in mental status.

Other Examples of Acute Mental Status Changes

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

Coding Instructions for C1310B, Inattention

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

Examples

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

Coding: Item C1310B would be **coded 0, behavior not present.**

Rationale: Ms. M remained focused throughout the interview and this was constant during the look-back period.

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

Coding: Item C1310B would be **coded 1, behavior continuously present, does not fluctuate. Rationale:** Ms. P’s attention consistently wandered throughout the 7-day look-back period. Ms. P’s dementia diagnosis does not affect the coding.

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

Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**

Rationale: Evidence of inattention was found during the BIMS but was noted to be absent in the medical record. This disagreement shows possible fluctuation in the behavior.

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

Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**

Rationale: Mrs. Y’s attention fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2.**

Pediatric Tip:

Code Inattention if present, even if age appropriate.

Coding Instructions for C1310C, Disorganized Thinking

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

Examples

1. The interviewer asks Mr. U, who is often confused, to give the date, and the response is: “Let’s go get the sailor suits!” He continues to provide irrelevant or nonsensical responses throughout the interview, and the caregiver indicates this is constant.

Coding: C1310C would be **coded 1, behavior continuously present, does not fluctuate.**

Rationale: All sources agree that the disorganized thinking is constant.

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

Coding: C1310C would be **coded 0, behavior not present.**

Rationale: Mrs. A’s answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

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

Coding: C1310C would be **coded 2, behavior present, fluctuates.**

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

Coding Instructions for C1310D, Altered Level of Consciousness

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

Coding Tip

- A diagnosis of coma or stupor does not have to be present for the caregiver to note the behavior in this section.

Examples

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

Coding: C1310D would be **coded 0, behavior not present.**

Rationale: All evidence indicates that the Ms. D is alert during conversation, interview(s) and activities.

2. Ms. E is lying in bed. She arouses to soft touch but is only able to converse for a short time

before her eyes close, and she appears to be sleeping. Again, she arouses to voice or touch but only for short periods during the interview. Information from other sources indicates that this was her condition throughout the look-back period.

Coding: C1310D would be **coded 1, behavior continuously present, does not fluctuate.**

Rationale: The individual's lethargy was consistent throughout the interview, and there is consistent documentation of lethargy in the medical record during the look-back period.

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

Coding: C1310D would be **coded 2, behavior present, fluctuates.**

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

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 OR Item B, C or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 OR **Item D = 1 OR 2**

SECTION D: MOOD

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

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

- Depression can be associated with:
 - psychological and physical distress (e.g., poor adjustment to a new setting, loss of

- independence, chronic illness, increased sensitivity to pain),
- decreased participation in therapy and activities (e.g., caused by isolation),
- decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and
- poorer outcomes (e.g., decreased appetite, decreased cognitive status).
- Findings suggesting mood distress should lead to:
 - identifying causes and contributing factors for symptoms,
 - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and
 - ensuring an individual’s safety.

D0100: Should Individual Mood Interview Be Conducted?

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

D0100. Should Individual Mood Interview be Conducted? – Attempt to conduct interview with the individual	
Enter <input type="checkbox"/> Code	0. No (Individual is rarely/never understood) OR individual is less than 7 years of age → Skip to and complete D0500 -D0600, Caregiver Assessment of Individual Mood(PHQ-9-OV)
	1. Yes → Continue to D0200, Individual Mood Interview (PHQ-9©)

Item Rationale

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

Health-related Quality of Life

- Most individuals who are capable of communicating are able to answer questions about how they feel.
- Obtaining information about mood directly from the individual, sometimes called “hearing the individual’s voice,” is more reliable and accurate than observation alone for identifying a mood disorder.

Planning for Care

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

Steps for Assessment

1. Review **Makes Self Understood** item (B0700) to determine if the individual is understood at least sometimes (B0700 = 0, 1, or 2).

2. Review **Language** item (A1100) to determine if the individual needs or wants an interpreter to communicate with doctors or health caregivers (A1100 = 1).
 - If the individual needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

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

Pediatric Tip

If the child is less than 7 years old skip to D0500. If the child is 7 years old or greater, use nursing judgment to determine whether to complete this section or skip to D0500 (**Caregiver Assessment of Mood**).

D0200: Individual Mood Interview (PHQ-9©) (14-Day Look-Back)

D0200. Individual Mood Interview (PHQ-9©)		
Say to individual: "Over the last 2 weeks, have you been bothered by any of the following problems?"		
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.		
If yes in column 1, then ask the individual: "About how often have you been bothered by this?"		
Read and show the individual a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.		
1. Symptom Presence	2. Symptom Frequency	
0. No (enter 0 in column 2)	0. Never or 1 day	1. Symptom Presence
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)	
9. No response (leave column 2 blank)	2. 7-11 days (half or more of the days)	
	3. 12-14 days (nearly every day)	
		2. Symptom Frequency
↓ Enter Scores in Boxes ↓		
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>

Definitions:

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

Item 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 often under-diagnosed and under treated.

Planning for Care

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

Steps for Assessment

Look-back period for this item is 14 days.

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

that the individual can see the print. Provide large print or assistive device (e.g., page magnifier) if necessary.

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

Coding Instructions for Column 1. Symptom Presence

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

Coding Instructions for Column 2. Symptom Frequency

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

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

Coding Tips and Special Populations

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

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some individuals may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
 - **Example:** Say, “That’s interesting, now I need to know...”; “Let’s get back to...”; “I understand, can you tell me about...”
- Validate your understanding of what the individual is saying by asking for clarification.

- **Example:** Say, “I think I hear you saying that...”; “Let’s see if I understood you correctly.”; “You said... Is that right?”
- If the individual has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
 - **Example:** Say, “Would you say [name symptom] bothered you more than half the days in the past 2 weeks?”
 - If the individual says “yes,” show the cue card and ask whether it bothered her nearly every day (12-14 days) or on half or more of the days (7-11 days).
 - If the individual says “no,” show the cue card and ask whether it bothered her several days (2-6 days) or never or 1 day (0-1 day).
- Noncommittal responses such as “not really” should be explored. Individuals may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered them, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:
 - “What do you mean?”
 - “Tell me what you have in mind.”
 - “Tell me more about that.”
 - “Please be more specific.”
 - “Give me an example.”
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
 - **Example:** Item D0200A, **Little Interest or Pleasure in Doing Things**. The individual, when asked how often he or she has been bothered by little interest or pleasure in doing things, responds, “There’s nothing to do here, all you do is eat, bathe, and sleep. They don’t do anything I like to do.”
 - Possible interview response: “You’re saying there isn’t much to do here and I want to come back later to talk about some things you like to do. Thinking about how you’ve been feeling over the past 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 individual, when asked how often he or she has been bothered by feeling down, depressed, or hopeless, responds: “How would you feel if you had to leave your home?”
 - Possible interview response: “You asked how I would feel, but it is important that I understand **your** feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last 2 weeks?”
- If the individual has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if an individual has moderate cognitive impairment but can respond to simple, direct questions.
 - **Example:** Item D0200C, **Trouble Falling or Staying Asleep, or Sleeping Too Much**.
 - You can break the item down as follows: “How often are you having problems falling asleep?” (pause for response) “How often are you having problems staying asleep?” (pause for response) “How often do you feel you are sleeping too much?”
 - **Example:** Item D0200E, **Poor Appetite or Overeating**. The individual responds “the

food is always cold and it just doesn't taste like it does at home. The doctor won't let me have any salt."

- You can simplify this item by asking: "In the last 2 weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?"
- Possible interviewer response: "You're telling me the food isn't what you eat at home and you can't add salt. How often would you say that you were bothered by poor appetite or over-eating during the last 2 weeks?"
- **Example: Item D0200H, Moving or Speaking So Slowly That Other People Could Have Noticed. Or the Opposite—Being So Fidgety or Restless That You Have Been Moving Around a Lot More than Usual.**
 - You can simplify this item by asking: "How often are you having problems with moving or speaking so slowly that other people could have noticed?" (pause for response) "How often have you felt so fidgety or restless that you move around a lot more than usual?"

Pediatric Tips

Complete this section only if the child is 7 years old or greater and able to respond to the questions. You can get parent/caregiver input to these questions even when interviewing the child, especially for F, G, H, and I and for Symptom Frequency. However, if 50 percent or more of the information is obtained from the parent/caregiver then switches to conducting the Caregiver Assessment of Mood, D0400.

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

D0300: Total Severity Score ®

D0300. Total Severity Score	
<input type="text"/>	The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-27). A score of 99 indicates that the individual was unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).
Enter Score	

Definitions

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

Item Rationale

Health-related Quality of Life

- The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the individual's physician, other clinicians and mental health specialists for appropriate follow up.

- The **Total Severity Score** is a summary of the frequency scores on the PHQ-9© that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessment by providers or mental health specialists.

Planning for Care

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

Steps for Assessment

After completing D0200 A-I:

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

Coding Instructions

- The interview is successfully completed if the individual answered the frequency responses of at least 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 **Caregiver Assessment of Mood** should be conducted.
- Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27** (or “99” if symptom frequency is blank for 3 or more items).

Coding Tips and Special Populations

- Responses to PHQ-9© can indicate possible depression. Responses can be interpreted as follows:
 - Major Depressive Syndrome is suggested if—of the 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

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

1. If all of the items in Column 2 have valid values (0,1,2,3), then D0300 should equal the simple sum of those values.
2. If any of the items in Column 2 are missing (i.e. if they are blank because the corresponding item in Column 1 is equal to [9]), then count their values as zero in computing the sum.
3. If the number of missing items in Column 2(as defined above) is equal to one, then compute the simple sum of the eight items in Column 2 that have valid values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in D0300.
4. If the number of missing items in Column 2(as defined above) is equal to two, then compute the simple sum of the 7 items in Column 2 that have valid values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in D0300.
5. If the number of missing items in Column 2(as defined above) is equal to three or more, then D0300 should equal [99]on the LTC Online Portal.

D0500: Caregiver Assessment of Individual Mood (PHQ-9-OV©) (14-Day Look-Back)

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

Item Rationale

Health-related Quality of Life

- PHQ-9© **Individual Mood Interview** is preferred as it improves the detection of a possible mood disorder. However, a small percentage of individuals are unable or unwilling to complete the PHQ-9© **Individual Mood Interview**. Therefore, the nurse assessor should complete the PHQ-9-OV© **Caregiver Assessment of Mood** so that any behaviors, signs, or symptoms of mood distress are identified and treated.
- Persons unable to complete the PHQ-9© **Individual Mood Interview** may still have a mood disorder.
- Even if an individual was unable to complete the **Individual Mood Interview**, important insights may be gained from the responses that were obtained during the interview, as well as observations of the individual's behaviors and affect during the interview.
- The identification of these behaviors and observations are important in the detection of mood distress, as the signs and symptoms are very treatable.
- It is important to note that coding the presence of indicators in Section D does not automatically mean that the individual has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators.
- Alternate means of assessing mood must be used for individuals who cannot communicate or refuse or are unable to participate in the PHQ-9© **Individual Mood Interview**. This ensures that information about their mood is not overlooked.

Planning for Care

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

Steps for Assessment

Look-back period for this item is 14 days.

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

Examples of Caregiver Responses That Indicate Need for Follow-up

1. **D0500A, Little Interest or Pleasure in Doing Things**
 - He doesn't really do much.
 - He spends most of the time in his room.
2. **D0500B, Feeling or Appearing Down, Depressed, or Hopeless**
 - She cries frequently.
3. **D0500C, Trouble Falling or Staying Asleep, or Sleeping Too Much**
 - Her back hurts when she lies down.
 - He urinates a lot during the night.
4. **D0500D, Feeling Tired or Having Little Energy**
 - She is frequently tired.
 - He is having a bad spell with his COPD right now.
5. **D0500E, Poor Appetite or Overeating**
 - She has not wanted to eat much of anything lately.
 - He has a voracious appetite, more so than last week.
6. **D0500F, Indicating That S/he Feels Bad about Self, Is a Failure, or Has Let Self or Family Down**
 - She does get upset when there's something she can't do now because of her stroke.
 - He gets embarrassed when he can't remember something he thinks he should be able to.
7. **D0500G, Trouble Concentrating on Things, Such as Reading the Newspaper or Watching Television**
 - She says there's nothing good on TV.
 - She never watches TV.
 - He can't see to read a newspaper.
8. **D0500H, Moving or Speaking So Slowly That Other People Have Noticed. Or the Opposite— Being So Fidgety or Restless That S/he Has Been Moving Around a Lot More than Usual**
 - His arthritis slows him down.
 - He's bored and always looking for something to do.
9. **D0500I, States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self**
 - She says God should take her already.
 - He complains that man was not meant to live like this.
10. **D0500J, Being Short-Tempered, Easily Annoyed**
 - She's OK if you know how to approach her.
 - He can snap but usually when his pain is bad.

Coding Instructions for Column 1. Symptom Presence

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

Coding Instructions for Column 2. Symptom Frequency

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

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

Coding Tips and Special Populations

- Ask the caregiver to select how often over the past 2 weeks the symptom occurred. Use the descriptive and/or numeric categories on the form (e.g., “nearly every day” or 3 = 12-14 days) to select a frequency response.
- If you separated a longer item into its component parts, select the **highest** frequency rating that is reported.
- If the caregiver has difficulty selecting between two frequency responses, code for the **higher** frequency.
- Also, you may review medical records, if available, to select the frequency code.

Pediatric Tips

Complete section (D0500) if the child is less than 7 years old or if the assessing nurse determines that the child is unable to answer section D0200.

D0600: Total Severity Score ®

D0600. Total Severity Score	
<input type="text"/> <small>Enter Score</small>	<small>The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-30).</small>

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Coding Instructions

The interview is successfully completed if the individual or caregiver were able to answer the

frequency responses of at least 7 out of 10 items on the PHQ-9-OV©.

Coding Tips and Special Populations

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

SECTION E: BEHAVIOR

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

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

E0100: Potential Indicators of Psychosis ®

E0100. Potential Indicators of Psychosis	
↓ Check all that apply	
<input type="checkbox"/>	A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli)
<input type="checkbox"/>	B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
<input type="checkbox"/>	Z. None of the above

Definition

Hallucination - The perception of the presence of something that is not actually there. It may be auditory or visual or involve smell, tastes or touch.

Delusion - A fixed, false belief not shared by others that the individual holds even in the face of the contrary.

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

1. Review the individual's medical record, if available, for the 7-day look-back period.
2. Interview the individual and caregivers regarding evidence of psychosis during the 7-day look-back period.
3. Observe the individual during conversations and the structured interviews in other assessment sections and listen for statements indicating an experience of hallucinations, or the expression

of false beliefs (delusions).

4. Clarify potentially false beliefs:

- When an individual expresses a belief that is plausible but alleged by others to be false (e.g., history indicates that the individual’s husband died 20 years ago, but the individual states her husband has been visiting her every day), try to verify the facts to determine whether there is reason to believe that it could have happened or whether it is likely that the belief is false.
- When an individual expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. Do not, however, challenge the individual.
- The individual’s response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed.

Coding Instructions

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

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

Coding Tips and Special Populations

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

Pediatric Tips

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

Examples

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

Coding: E0100A would be **checked**.

Rationale: She reports an auditory sensation that occurs in the absence of any external stimulus. Therefore, this is a hallucination.

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

Coding: E0100Z would be **checked**.

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

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

Coding: E0100B would be **checked**.

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

E0200: Behavioral Symptom—Presence & Frequency ®

E0200. Behavioral Symptom - Presence & Frequency	
Note presence of symptoms and their frequency	
Coding: 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	<input type="checkbox"/> B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)
<input type="checkbox"/> C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)	

Item Rationale

Health-related Quality of Life

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

disability and distress.

Planning for Care

- Identification of the frequency and the impact of behavioral symptoms, on the individual and on others, are critical to distinguish behaviors that constitute problems—and may therefore require treatment planning and intervention—from those that are not problematic.
- These behaviors may indicate unrecognized needs, preferences, or illness.
- Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and interventions can be developed to improve the symptoms or reduce their impact.
- Subsequent assessments and documentation can be compared to baseline to identify changes in the individual's behavior, including response to interventions.

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

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

Example

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

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

E0300: Overall Presence of Behavioral Symptoms

E0300. Overall Presence of Behavioral Symptoms	
Enter Code <input type="checkbox"/>	Were any behavioral symptoms in questions E0200 coded 1, 2, or 3? 0. No → Skip to E0800, Rejection of Care 1. Yes → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

Item Rationale

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

Step for Assessment

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

Coding Instructions

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

E0500: Impact on Individual

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

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

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

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

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

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

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

Coding Tips and Special Populations

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

Examples

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

Coding: E0500B would be **coded 1, yes**

Rationale: This behavior interfered with delivery of essential personal care.

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

Coding: E0500A and E0500B would both be **coded 1, yes**.

Rationale: The behavior interfered significantly with delivery of her care and put her at clinically significant risk for physical illness.

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

Coding: E0500C would be **coded 1, yes**.

Rationale: The behavior interfered with his ability to participate in any activities.

E0600: Impact on Others

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

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

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

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

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

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

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

Coding Tips and Special Populations

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

Example

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

Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes**.

Rationale: This is an intrusion and violates the daughter’s privacy.

E0800: Rejection of Care—Presence & Frequency ®

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Evaluation of rejection of care assists the provider in honoring the individual's care preferences in order to meet his or her desired health care goals.
- Follow-up assessment should consider:
 - Whether established care goals clearly reflect the individual's preferences and goals, and

- Whether alternative approaches could be used to achieve the individual's care goals.
- Determine whether a previous discussion identified an objection to the type of care or the way in which the care was provided. If so, determine approaches to accommodate the individual's preferences.

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

- The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the individual's preferences

or goals for health and well-being or a choice made on behalf of the individual by a caregiver or family member or other proxy decision maker.

- Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the individual or caregiver) and determined to be consistent with the individual's values, preferences, or goals. Individuals, who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."

Examples

1. Mr. W goes to bed at night without changing out of the clothes he wore during the day. When the caregiver offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened 2 of the past 5 days. He was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.

Coding: E0800 would be **coded 1, behavior of this type occurred 1-3 days.**

Rationale: His care rejection behavior is not consistent with his values and goals for health and well-being. Therefore, this is classified as care rejection that occurred twice.

2. Ms. G is given her antibiotic medication prescribed for treatment of pneumonia and immediately spits the pills out on the floor. Her assessment indicates that she does not have any swallowing problems. This happened on each of the last 4 days. Her advance directive indicates that she would choose to take antibiotics to treat a potentially life-threatening infection.

Coding: E0800 would be **coded 2, behavior of this type occurred 4-6 days, but less than daily.**

Rationale: The behavioral rejection of antibiotics prevents her from achieving her stated goals for health care listed in her advance directives. Therefore, the behavior is coded as care rejection.

3. Ms. L who previously ate well and prided herself on following a healthy diet has been refusing to eat every day for the past 2 weeks. She complains that the food is boring and that she feels full after just a few bites. She says she wants to eat to maintain her weight and avoid getting sick, but cannot push herself to eat anymore.

Coding: E0800 would be **coded 3, behavior of this type occurred daily.**

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

E0900: Wandering—Presence & Frequency ®

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

1. Review the medical record, if available, and interview the caregiver to determine whether wandering occurred during the 7-day look-back period.
 - Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering individual may be oblivious to his/her physical or safety needs. The individual may have a purpose such as searching to find something, but he/she persists without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when an individual believes he/she must find his/her mother, who caregivers know is deceased).
2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period.

Coding Instructions for E0900

- **Code 0, behavior not exhibited:** if wandering was not exhibited during the 7-day look-back

period. Skip to **Change in Behavior or Other Symptoms** item (E1100).

- **Code 1, behavior of this type occurred 1-3 days:** if the individual wandered on 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the individual wandered on 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).
- **Code 3, behavior of this type occurred daily:** if the individual wandered daily during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).

Coding Tips and Special Populations

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

E1000: Wandering—Impact

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

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

- The plan of care should consider the impact of wandering on individual safety and disruption to others.
- The plan of care should be focused on minimizing these issues.
- Determine the need for environmental modifications (door alarms, door barriers, etc.) that enhance individual safety if wandering places the individual at risk.

- Determine when wandering requires interventions to reduce unwanted intrusions on other individuals or disruption of the living environment.

Steps for Assessment

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

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

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

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

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

Example

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

Coding: E1000A would be **coded 1, yes.**

Rationale: Wandering that resulted in elopement from his home placed him at significant risk.

E1100: Change in Behavior or Other Symptoms

E1100. Change in Behavior or Other Symptoms – Consider all of the symptoms assessed in items E0100 through E1000.	
How does individual's current behavior status, care rejection, or wandering compare to prior assessment?	
Enter <input type="text"/> Code	0. Same 1. Improved 2. Worse 3. N/A because no prior assessment

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

Coding Tips

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

Example

1. At the time of the last assessment, Mr. D was ambulatory and would threaten and hit family members on a daily basis. He recently suffered a hip fracture and is not ambulatory. He is not approaching, threatening, or assaulting family members however, he is now combative when his caregiver tries to assist with dressing and bathing, and is hitting his caregiver on a daily basis.

Coding: E1100 would be **coded 0, same.**

Rationale: Although he is no longer assaulting family the danger to others and the frequency of these behaviors is the same as before, the overall behavior is rated as unchanged.

SECTION G: FUNCTIONAL STATUS

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. Individual and caregiver opinions regarding functional rehabilitation potential are captured in the assessment.

G0110: Activities of Daily Living (ADL) Assistance

G0110. Activities of Daily Living (ADL) Assistance						
<p>Instructions for Rule of 3</p> <ul style="list-style-type: none"> ■ 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: <ul style="list-style-type: none"> ○ When there is a combination of full caregiver performance, and extensive assistance, code extensive assistance. ○ When there is a combination of full caregiver performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2). <p>If none of the above are met, code supervision.</p>						
<p>1. ADL Self-Performance</p> <p>Code for individual's performance - 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 caregiver performance every time</p> <p>Coding:</p> <p>Activity Occurred 3 or More Times</p> <ol style="list-style-type: none"> 0. Independent - no help or caregiver oversight at any time 1. Supervision - oversight, encouragement or cueing 2. Limited assistance - individual highly involved in activity; caregiver provide guided maneuvering of limbs or other non-weight-bearing assistance 3. Extensive assistance - individual involved in activity, caregiver provide weight-bearing support 4. Total dependence - full caregiver performance every time during entire 7-day period <p>Activity Occurred 2 or Fewer Times</p> <ol style="list-style-type: none"> 7. Activity occurred only once or twice - activity did occur but only once or twice 8. Activity did not occur - activity (or any part of the ADL) was not performed by individual or caregiver at all over the entire 7-day period 	<p>2. ADL Support Provided</p> <p>Code for most support provided; code regardless of individual's self-performance classification</p> <p>Coding:</p> <ol style="list-style-type: none"> 0. No setup or physical help from caregiver 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire period 					
	<table border="1"> <thead> <tr> <th>1. Self-Performance</th> <th>2. Support</th> </tr> </thead> <tbody> <tr> <td colspan="2" style="text-align: center;">↓ Enter Codes in Boxes ↓</td> </tr> </tbody> </table>	1. Self-Performance	2. Support	↓ Enter Codes in Boxes ↓		
1. Self-Performance	2. Support					
↓ Enter Codes in Boxes ↓						
A. Bed mobility - how individual moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	<input type="checkbox"/>	<input type="checkbox"/>				
B. Transfer - how individual moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)	<input type="checkbox"/>	<input type="checkbox"/>				
C. Walk in room - how individual walks between locations in room	<input type="checkbox"/>	<input type="checkbox"/>				
D. Walk in home - how individual walks in home or community setting	<input type="checkbox"/>	<input type="checkbox"/>				
E. Locomotion in room - how individual moves between locations in his/her room and adjacent hallway on same floor. If in wheelchair, self-sufficiency once in chair	<input type="checkbox"/>	<input type="checkbox"/>				
F. Locomotion in home - how individual moves to and returns from distant areas in his/her home or community setting. If in wheelchair, self-sufficiency once in chair	<input type="checkbox"/>	<input type="checkbox"/>				
G. Dressing - how individual puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	<input type="checkbox"/>	<input type="checkbox"/>				
H. Eating - how individual 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)	<input type="checkbox"/>	<input type="checkbox"/>				
I. Toilet use - how individual 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	<input type="checkbox"/>	<input type="checkbox"/>				
J. Personal hygiene - how individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)	<input type="checkbox"/>	<input type="checkbox"/>				

Definitions

ADL – tasks related to personal care; any of the tasks listed in item G0110A-J and G0120

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 individual actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

ADL Support Provided – Measures the highest level of support provided by caregivers over the last 7 days, even if that level of support only occurred once.

Item Rationale

Health-related Quality of Life

- Some individuals in a community setting need physical assistance. In addition, some are at risk of further physical decline.
- 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/injuries, falls, contractures, depression, and muscle wasting may occur.

Planning for Care

- Individualized plans of care should address strengths and weaknesses, 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 individuals, cognitive deficits can limit ability or willingness to initiate or participate in self-care or restrict understanding of the tasks required to complete ADLs.
- An individual's potential for maximum function may be underestimated by family, caregivers, and the individual. Individualized plans of care should be based on an accurate assessment of the individual's self-performance and the amount and type of support being provided to the individual.
- Some individuals might require lower levels of assistance if they are provided with appropriate devices and aids, assisted with segmenting tasks, or are given adequate time to complete the task while being provided graduated prompting and assistance. This type of supervision requires skill, time, and patience.
- Some individuals in the community setting are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.

- Graduated prompting/task segmentation (helping the individual break tasks down into smaller components) and allowing the individual time to complete an activity can often increase functional independence.

Steps for Assessment

1. Review the documentation in the medical record, if available, for the 7-day look-back period.
2. Talk with caregivers to learn what the individual does for himself during each episode of each ADL activity definition as well as the type and level of caregiver assistance provided. Remind caregivers that the focus is on the 7-day look-back period only.
3. When reviewing records, interviewing caregivers, and observing the individual, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, determine the level of assistance required for moving the individual to and from a lying position, for turning the individual from side to side, and/or for positioning the individual in bed.
4. To clarify your own understanding and observations about an individual's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See "Example of a Probing Conversation with Caregivers" later in this section for using probes when talking to caregivers.

Coding Instructions

For each ADL activity:

- To assist in coding ADL self-performance items, you may use the flow diagram found later in this section.
- Consider each episode of the activity that occurred during the 7-day look-back period.
- In order to be able to promote the highest level of functioning among individuals, caregivers must first identify what the individual actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.).
- Code based on the individual's level of assistance when using special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handle reacher, or adaptive eating utensils.
- An individual's ADL self-performance may vary from day to day. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a caregiver that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the individual's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the nurse assessor sees the individual, but how the individual actually performs).
- The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common. Refer to the flow chart later in this section for assistance in determining the most appropriate self-performance code.
- Although it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days.

- Because this section involves a two-part evaluation (ADL Self-Performance and ADL Support), each using its own scale, it is recommended that the Self-Performance evaluation be completed for all ADL activities before beginning the ADL Support evaluation.

Instructions for the Rule of Three:

- 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.**
 - Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3). Exceptions are as follows:
 - Total dependence (4)—activity must require full assist every time, and
 - Activity did not occur (8)—activity must not have occurred at all or family and/or caregiver provided care 100 percent of the time for that activity over the entire 7-day period.
- 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 caregiver performance and extensive assistance, code extensive assistance (3).
 - When there is a combination of full caregiver performance, weight-bearing assistance and/or non-weight-bearing assistance, code limited assistance (2).
- **If none of the above are met, code supervision.**

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

- **Code 0, independent:** if individual completed activity with no help or oversight every time during the 7-day look-back period.
- **Code 1, supervision:** if oversight, encouragement, or cueing was provided **three** or more times during the last 7 days.
- **Code 2, limited assistance:** if individual 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 individual performed part of the activity over the last 7 days, help of the following type(s) was provided three or more times:
 - Weight-bearing support provided three or more times.
 - Full caregiver performance of activity during part but not all of the last 7 days.
- **Code 4, total dependence:** if there was full caregiver performance of an activity with no participation by individual for any aspect of the ADL activity. The individual 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 but **not** three times or more.
- **Code 8, activity did not occur:** if, over the 7-day look-back period, the ADL activity (or any part of the ADL) was not performed by the individual or caregiver at all.

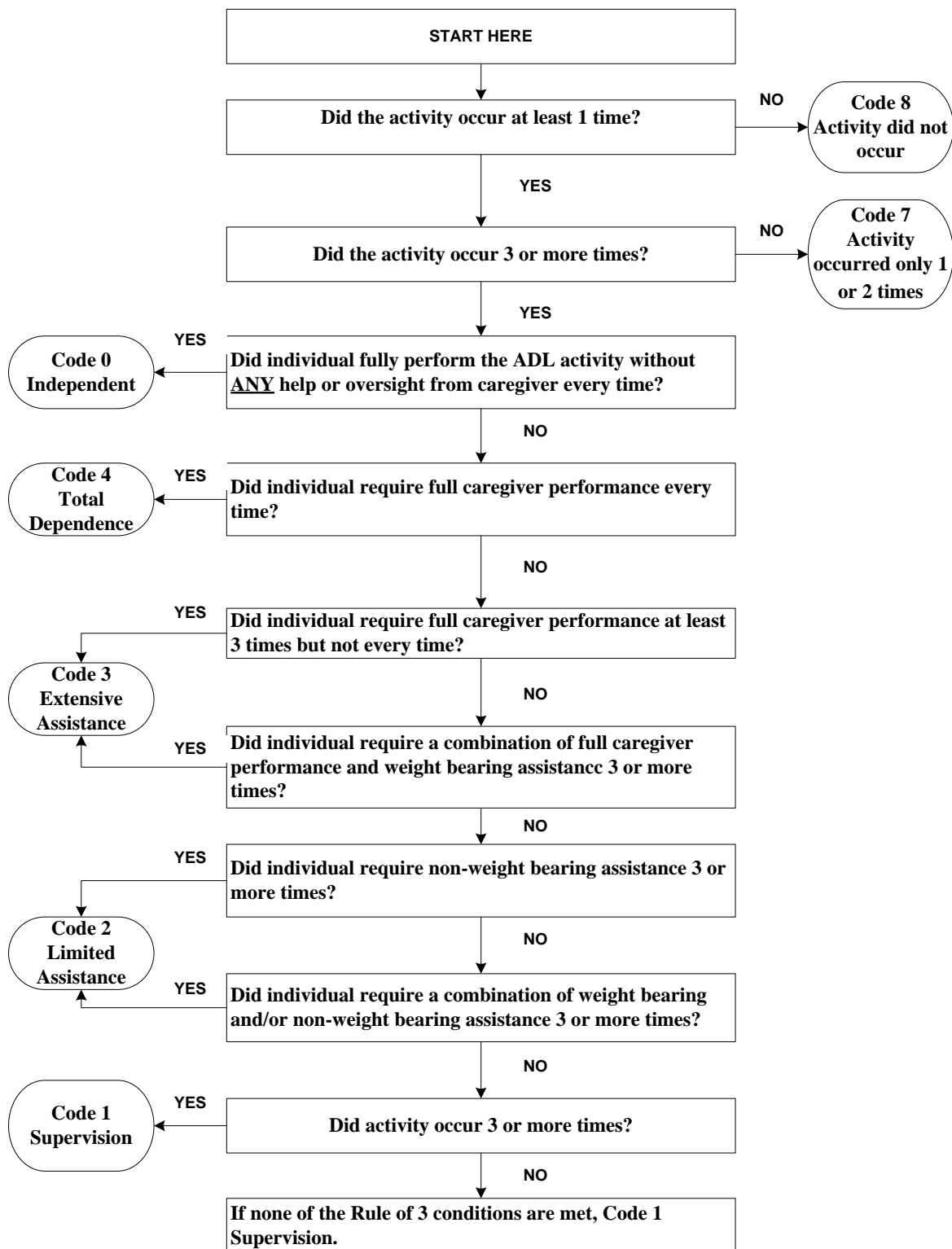
Coding Instructions for G0110, Column 2, ADL Support Provided

Code for the most support provided; code regardless of individual's self-performance classification.

- **Code 0, no setup or physical help from caregivers:** if individual completed activity with no help or oversight.
- **Code 1, setup help only:** if individual is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the individual takes from the caregiver.
- **Code 2, one person physical assist:** if the individual was assisted by one caregiver.
- **Code 3, two+ person physical assist:** if the individual was assisted by two or more caregivers.
- **Code 8, ADL activity itself did not occur during the entire period:** if, over the 7-day look-back period, the ADL activity did not occur.

ADL Self-Performance Coding Flow Diagram

Instructions: Follow arrows on flowchart to determine correct coding, starting at the “Did Activity Occur” box.



Coding Tips and Special Populations

- Some individuals sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the individual's extremity or body. For example, if the caregiver supports some of the weight of the individual's hand while helping the individual to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the individual, this is "weight-bearing" assistance for this activity. If the individual can lift the utensil or cup, but the caregivers assistance is needed to guide the individual's hand to his or her mouth, this is guided maneuvering.
- Do **NOT** record the caregiver's assessment of the individual's potential capability to perform the ADL activity. The assessment of potential capability is covered in **ADL Functional Rehabilitation Potential** Item (G0900).
- Do **NOT** record the type and level of assistance that the individual "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.
- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0100I
- **Some examples for coding for ADL Support Setup Help when the activity involves the following:**
 - Bed Mobility—handing the individual the bar on a trapeze, the caregiver raises the ½ rails for the individual's use and then provides no further help.
 - Transfer—giving the individual a transfer board or locking the wheels on a wheelchair for safe transfer.
 - Locomotion
 - Walking—handing the individual a walker or cane.
 - Wheeling—unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
 - Dressing—retrieving clothes from the closet and laying out on the individual's bed; handing the individual a shirt.
 - Eating—cutting meat and opening containers at meals; giving one food item at a time.
 - Toilet Use—handing the individual a bedpan or placing articles necessary for changing an ostomy appliance within reach.
 - Personal Hygiene—providing a washbasin and grooming articles.
- **Supervision**
 - **Code Supervision** for individuals 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 an individual 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.
 - **Locomotion** would be **coded 8, activity did not occur:** if the individual was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period.

- **Eating** would be **coded 8, activity did not occur**: only if the individual received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period.
- **Individuals with tube feeding, TPN, or IV fluids**
 - **Code extensive assistance (1 or 2 persons)**: if the individual 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 caregiver completed a portion of the ADL activity for the individual (managing the tube feeding, TPN, or IV fluids).
 - **Code totally dependent in eating**: only if individual was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by the caregiver) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

Example of a Probing Conversation with Caregivers

1. Example of a probing conversation between the nurse assessor (RN) and a caregiver (CG) regarding an individual's bed mobility assessment:

RN: "Describe to me how Mrs. L. moves herself in bed. By that I mean once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side and positioning herself?"

CG: "She can lie down and sit up by herself, but I help her turn on her side."

RN: "She lies down and sits up without any verbal instructions or physical help?"

CG: "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

RN: "How do you help her turn side to side?"

CG: "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

RN: "Do you lift her by yourself or does someone help you?"

CG: "I do it by myself."

RN: "How many times during the last 7 days did you give this type of help?"

CG: "Every day, probably 3 times each day."

In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the individual positions herself while in bed. An individual can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of actual assistance Mrs. L. received. Because accurate coding is important as a basis for reporting on the type and amount of care provided, be sure to consider each activity definition fully.

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

Examples for G0110A, Bed Mobility ®

1. Mrs. D. can easily turn and position herself in bed and is able to sit up and lie down without any caregiver assistance at any time during the 7-day look-back period. She requires use of a single side rail that the caregiver places in the up position when she is in bed.

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

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

- 2 Ms. I favors lying on her right side. Because she has had a history of skin breakdown, caregivers must verbally remind her to reposition off her 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 caregivers**

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

- 3 Ms. J favors lying on her right side. Because she has had a history of skin breakdown, caregivers must sometimes cue the individual and guide (non-weight-bearing assistance) the individual to place her hands on the side rail and encourage her to change her 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: She requires cueing and encouragement with setup and non-weight-bearing physical help daily during the 7-day look-back period.

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

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

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

- 5 Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two caregivers must physically turn her every 2 hours without any participation at any time from her at any time during the 7-day look-back period. She 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: She did not participate at any time during the 7-day look-back period and required two caregivers to position her in bed.

Examples for G0110B, Transfer ®

1. When transferring from bed to chair or chair back to bed, Ms. N 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 caregiver**

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

2. The caregiver must supervise Ms. K as she transfers from her bed to wheelchair daily. The caregiver must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

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

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

3. Mrs. H. is able to transfer from the bed to chair when she uses her walker. Caregivers place the walker near her bed and then assist the individual with guided maneuvering as she transfers. She 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: She requires caregivers to set up her walker and provide non-weight-bearing assistance when she is ready to transfer. The activity happened six times during the 7-day look-back period.

4. Mrs. B. requires weight-bearing assistance of one caregiver to partially lift and support her when being transferred. She 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: She partially participates in the task of transferring. The individual was noted to have transferred 14 times during the 7-day look-back period, each time requiring weight-bearing assistance of one caregiver.

5. Mr. T. is in a physically debilitated state due to surgery. Two caregivers must physically lift and transfer him to a reclining chair daily using a mechanical lift. Mr. 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: He did not participate and required two caregivers to transfer him out of his bed. The individual was transferred out of bed to the chair daily during the 7-day look-back period.

6. Mrs. D. is post-operative for extensive surgical procedures. Because of her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest. During the 7-day look-back period the individual 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.**

Rationale: Activity did not occur.

7. Mr. M. has Parkinson's disease and needs weight-bearing assistance of two caregivers to transfer from his bed to his wheelchair. During the 7-day look-back period, Mr. 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 caregivers.

Pediatric Tip

An infant is carried from one surface to another and does not participate at all in transferring.

Coding: G0110B1 would be coded 4, total dependence and G0110B2 would be coded 2, one person physical assist.

Examples for G0110C, Walk in Room

1. Mr. R. is able to walk freely in his room (obtaining clothes from closet, turning on TV) without any cueing or physical assistance from caregivers at all during the entire 7-day look-back period.

Coding: G0110C1 would be **coded 0, independent** G0110C2 would be **coded 0, no setup or physical help from caregivers**

Rationale: He is independent.

2. Mr. B. was able to walk in his room daily, but a caregiver was needed to cue and stand by during ambulation because the individual has had a history of an unsteady gait.

Coding: G0110C1 would be **coded 1, supervision** G0110C2 would be **coded 0, no setup or physical help from caregivers**

Rationale: He requires caregiver supervision, cueing, and reminders daily while walking in his room, but did not need setup or physical help from caregiver.

3. Mr. K. is able to walk in his room, and, with hand-held assist from one caregiver, the individual was noted to ambulate daily during the 7-day look-back period.

Coding: G0110C1 would be **coded 2, limited assistance** G0110C2 would be **coded 2, one person physical assist**

Rationale: He requires hand-held (non-weight-bearing) assistance of one caregiver daily for ambulation in his room.

4. Mr. A. has a bone spur on his heel and has difficulty ambulating in his room. He requires caregivers to help support him when he selects clothing from his closet. During the 7-day look-back period the individual was able to ambulate with weight-bearing assistance from one caregiver in his room four times.

Coding: G0110C1 would be **coded 3, extensive assistance** G0110C2 would be **coded 2, one person physical assist**

Rationale: He was able to ambulate in his room four times during the 7-day look-back period with weight-bearing assistance of one caregiver.

Examples for G0110D, Walk in Home

1. Mr. X. ambulated daily in his home or community setting with a cane and did not require any setup or physical help from caregivers at any time during the 7-day look-back period.

Coding: G0110D1 would be **coded 0, independent** G0110D2 would be **coded 0, no setup or physical help from caregiver**

Rationale: He requires no setup or help from the caregivers at any time during the entire 7-day look-back period.

2. The caregiver provided verbal cueing while Mr. K was walking in his home or community setting every day during the 7-day look-back period to ensure that the individual walked slowly and safely.

Coding: G0110D1 would be **coded 1, supervision** G0110D2 would be **coded 0, no setup or physical help from caregiver**

Rationale: He requires caregiver's supervision, cueing, and reminders daily while ambulating in his home or community setting during the 7-day look-back period.

3. Mrs. Q. requires verbal cueing and physical guiding of her hand placement on the walker when walking in the home or community setting. She needs frequent verbal reminders of how to use her walker, where to place her hands, and to pick up her feet. Mrs. Q. needs to be

physically guided. During the 7-day look-back period the individual was noted to ambulate in the home or community setting daily and required the above-mentioned support.

Coding: G0110D1 would be **coded 2, limited assistance** G0110D2 would be **coded 2, one person physical assist**

Rationale: She requires non-weight-bearing assistance of one caregiver for safe ambulation daily during the 7-day look-back period.

4. Mr. U had back surgery 2 months ago. Two caregivers must physically support him as he is walking in the home or community setting because of his unsteady gait and balance problem. During the 7-day look-back period he ambulated in the hallway three times with physical assist of two caregivers.

Coding: G0110D1 would be **coded 3, extensive assistance** G0110D2 would be **coded 3, two+ persons physical assist**

Rationale: He ambulated three times during the 7-day look-back period, with partial participation in the task. Two caregivers were required to physically support him so he could ambulate.

5. Mrs. J. ambulated in the home or community setting once with supervision and once with non-weight-bearing assistance of one caregiver during the 7-day look-back period.

Coding: G0110D1 would be **coded 7, activity occurred only once or twice** G0110D2 would be **coded 2, one person physical assist**

Rationale: The activity occurred only twice during the look-back period. It does not matter that the level of assistance provided by caregivers was at different levels. During ambulation, the most support provided was physical help by one caregiver.

Example for G0110E, Locomotion in Room

1. Mrs. L. is on complete bed rest. During the 7-day look-back period she did not get out of bed or leave the room.

Coding: G0110E1 would be **coded 8, activity did not occur** G0110E2 would be **coded 8, ADL activity itself did not occur during entire period**

Rationale: She was on bed rest during the look-back period and never left her room.

Pediatric Tips

A child uses a walker and is independent in using it after setup assistance-

Coding: G0110E1 would be coded 0, independent. G0110E2 would be coded 1, setup help only.

The parent/caregiver has to carry the child-

Coding: G0110E1 would be coded 4, total dependence. G0110E2 would be coded 2, one person physical assist.

For a crawling child-

Coding: G0110E1 would be coded 0, independent, or 1, supervision. G0110E2 would be coded 2, one person physical assist.

Rationale: A crawling child should never be left unattended.

Examples for G0110F, Locomotion in Home

1. Mr. Q. is a wheelchair-bound and is able to self-propel in the home or community setting. On two occasions during the 7-day look-back period, he self-propelled into the courtyard.

Coding: G0110E1 would be **coded 7; activity occurred only once or twice** G0110E2 would be **coded 0, independent**

Rationale: The activity happened only twice during the look-back period with no help or oversight from caregivers.

2. Mr. H. enjoyed walking in the garden when weather permitted. Due to inclement weather during the assessment period, he required various levels of assistance on the days he walked through the garden. On two occasions, he required limited assistance for balance of one caregiver and on another occasion he only required supervision. On one day he was able to walk through the garden completely by himself.

Coding: G0100F1 would be **coded 1, supervision** G0110F2 would be **coded 2, one person physical assist**

Rationale: Activity did not occur at any one level for three times and he did not require physical assistance for at least three times. The most support provided by caregivers was one person assist.

Pediatric Tips

A child uses a walker and is independent in using it after setup assistance.

Coding: G0110F1 would be coded 0, independent. G0110F2 would be coded 1, setup help only.

The parent/caregiver has to carry the child.

Coding: G0110F1 would be coded 4, total dependence. G0110F2 would be coded 2, one person physical assist.

For a crawling child.

Coding: G0110F1 would be coded 0, independent, or 1, supervision. G0110F2 would be

coded 2, one person physical assist.

Rationale: A crawling child should never be left unattended.

Example for G0110G, Dressing

1. Mrs. C. did not feel well and chose to stay in her room. She requested to stay in night clothes and rest in bed for the entire 7-day look-back period. Each day, after washing up, Mrs. C. changed night clothes with caregiver's assistance to guide her arms and assist in guiding her nightgown over her head and buttoning the front.

Coding: G0110G1 would be **coded 2, limited assistance** G0110G2 would be **coded 2, one person physical assist**

Rationale: She was highly involved in the activity and changed clothing daily with non-weight-bearing assistance from one caregiver during the 7-day look-back period.

Examples for G0110H, Eating ®

1. At meal time, Mr. K. consumes 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 caregiver**

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

2. One caregiver had to verbally cue Mr. D 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 caregiver**

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

3. Mr. V. is able to eat by himself. The caregiver must set up the meal, cut the meat, open containers, and hand him the utensils. Each day during the 7-day look-back period, Mr. V. required more help during the evening meal, as he was tired and less interested in completing his meal. In the evening, in addition to encouraging the individual to eat and handing him his utensils and cups, the caregiver must also guide his hand so he will get the utensil to his mouth.

Coding: G0110H1 would be **coded 2, limited assistance** G0110H2 would be **coded 2, one person physical assist**

Rationale: He is unable to complete the evening meal without the caregiver providing him non-weight-bearing assistance daily.

4. Mr. F. begins eating each meal daily by himself. During the 7-day look-back period, after he had eaten only his bread, he stated he was tired and unable to complete the meal. One

caregiver physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. He 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: He partially participated in the task daily at each meal, but one caregiver provided weight-bearing assistance with some portion of each meal.

5. Mrs. U. is severely cognitively impaired. She is unable to feed herself. During the 7-day look-back period, one caregiver had to assist her with eating every meal.

Coding: G0110H1 would be **coded 4, total dependence** G0110H2 would be **coded 2, one person physical assist**

Rationale: She did not participate and required one caregiver to feed her all of her meal during the 7-day look-back period.

6. Mrs. D. receives all of her nourishment via a gastrostomy tube. She did not consume any food or fluid by mouth. During the 7-day look-back period, she 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, she did not participate in eating and/or receiving of her tube feed during the entire period. She required full caregiver performance of these functions.

Pediatric Tips

An infant is fed from a bottle, breast fed, or spoon fed.

Coding: G0110H1 would be coded 4, total dependence and G0110H2 would be coded 2, one person physical assist

A child requires only cutting of food items and opening of containers but is otherwise independent.

Coding: G0110H1 would be coded, 0, independent. G0110H2 would be coded 1, setup help only.

A child with tube-feeding is receiving assistance in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by caregiver). Child does not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedures).

Coding: G0110H1 would be coded 4, total dependence. G0110H2 would be coded 2, one person physical assist.

Examples for G0110I, Toilet Use ®

1. Mrs. L. transferred herself to the toilet, adjusted her clothing, and performed the necessary personal hygiene after using the toilet without any caregiver 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 caregivers**

Rationale: She was independent in all her toileting tasks.

2. Caregivers must remind Mr. N to toilet frequently during the day and to unzip and zip pants and to wash his hands after using the toilet. During the 7-day look-back period, the individual required the above level of support multiple times each day.

Coding: G0110I1 would be **coded 1, supervision** G0110I2 would be **coded 0, no setup or physical help from caregivers**

Rationale: He required caregiver's supervision, cueing and reminders daily.

3. Caregivers must assist Mr. P. to zip his pants, hand him a washcloth, and remind him to wash his hands after using the toilet daily. During the 7-day look-back period, the individual required the above level of support multiple times each day.

Coding: G0110I1 would be **coded 2, limited assistance** G0110I2 would be **coded 2, one person physical assist**

Rationale: Individual required caregivers to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

4. Mrs. M. has had recent bouts of vertigo. During the 7-day look-back period, the individual required one caregiver to assist and provide weight-bearing support to her as she 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, she required weight-bearing assistance to use the commode four times.

5. Miss W. is cognitively and physically impaired. During the 7-day look-back period, she was on strict bed rest. Caregivers were unable to physically transfer her to toilet during this time. Miss W. is incontinent of both bowel and bladder. One caregiver was required to provide all the care for her elimination and personal hygiene needs several times each day.

Coding: G0110I1 would be **coded 4, total dependence** G0110I2 would be **coded 2, one person physical assist**

Rationale: She did not participate and required one caregiver to provide total care for toileting and personal hygiene each time during the entire 7-day look-back period.

Pediatric Tips

An infant/child in diapers or a child with an ostomy that the child does not manage themselves.

Coding: G0110I1 would be coded 4, total dependence and in G0110I2 would be coded 2, one person assist.

A child that needs extensive assistance to get on toilet due to their diagnosis or physical limitation.

Coding: G0110I2 would be coded 2 or 3 depending on the amount of assistance required.

Examples for G0110J, Personal Hygiene

1. The caregiver takes Mr. L.'s comb, toothbrush, and toothpaste from the drawer and places them at the bathroom sink. Mr. L. combs his own hair and brushes his own teeth daily. During the 7-day look-back period, he required cueing to brush his teeth on three occasions.

Coding: G0110J1 would be **coded 1, supervision** G0110J2 would be **coded 1, setup help only**

Rationale: Caregivers placed grooming devices at sink for his use, and during the 7-day look-back period caregivers provided cueing three times.

2. Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a caregiver did it for her.

Coding: G0110J1 would be **coded 2, limited assistance** G0110J2 would be **coded 2, one person physical assist**

Rationale: A caregiver had to complete part of the activity for the individual 3 days during the look-back period; the assistance was non-weight-bearing.

G0120: Bathing

G0120. Bathing	
How individual takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support	
Enter Code <input type="text"/>	A. Self-performance 0. Independent – no help provided 1. Supervision – oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during the entire period
Enter Code <input type="text"/>	B. Support provided (Bathing support codes are as defined in Item G0110 column 2, ADL Support Provided , above)

Definition

Bathing – When the individual takes a full-body bath, shower or sponge bath including transfers in and out of the tub or shower, it does not include the washing of back or hair.

Item Rationale

Health-related Quality of Life

- The individual's choices regarding his or her bathing schedule should be accommodated when possible.

Planning for Care

- The plan of care should include interventions to address the individual's unique needs for bathing. These interventions should be periodically evaluated and, if objectives were not met, alternative approaches developed to encourage maintenance of bathing abilities.

Coding Instructions for G0120 A, Self-Performance

Code for the maximum amount of assistance the individual received during the bathing episodes.

- **Code 0, independent:** if the individual required no help from caregivers.
- **Code 1, supervision:** if the individual required oversight help only.
- **Code 2, physical help limited to transfer only:** if the individual is able to perform the bathing activity, but required help with the transfer only.
- **Code 3, physical help in part of bathing activity:** if the individual required assistance with some aspect of bathing.
- **Code 4, total dependence:** if the individual is unable to participate in any of the bathing activity.
- **Code 8, activity itself did not occur:** if the individual was not bathed during the 7-day look-back period.

Coding Instructions for G0120B, Support Provided

- Bathing support codes are as defined **ADL Support Provided** item (G0110), Column 2.

Coding Tips

- Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G0110, **Column 1 (Self-Performance)**, do not apply. A unique set of self-performance codes is used in the bathing assessment given that bathing may not occur as frequently as the other ADL's in the 7-day look-back period.
- If an individual requires supervision when bathing (i.e., they are never left alone while in the bathroom for a bath or shower), it is appropriate to code the caregiver's support as supervision, even if the supervision is precautionary because this is individual supervision.

Examples

1. Mr. E received verbal cueing and encouragement to take twice-weekly showers. Once

caregivers walked individual to bathroom, he bathed himself with periodic oversight.

Coding: G0120A would be **coded 1, supervision** G0120B would be **coded 0, no setup or physical help from caregivers**

Rationale: He needed only supervision to perform the bathing activity with no setup or physical help from caregivers.

2. For one bath, Ms. R received physical help of one person to position self in bathtub. However, because of her fluctuating moods, she received total help for her other bath from one caregiver.

Coding: G0120A would be **coded 4, total dependence** G0120B would be **coded 2, one person physical assist**

Rationale: Coding directions for bathing state, “code for most dependent in self-performance and support.” Her most dependent episode during the 7-day look-back period was total help with the bathing activity with assist from one caregiver.

3. On Monday, one caregiver helped transfer Mr. F to tub and washed his legs. On Thursday, the individual had physical help of one person to get into tub but washed himself completely.

Coding: G0120A would be **coded 3, physical help in part of bathing activity** G0120B would be **coded 2, one person physical assist**

Rationale: His most dependent episode during the 7-day look-back period was assistance with part of the bathing activity from one caregiver.

G0300: Balance During Transitions and Walking

G0300. Balance During Transitions and Walking	
After observing the individual, code the following walking and transition items for most dependent	
↓ Enter Codes in Boxes	
Coding: 0. Steady at all times 1. Not steady, but <u>able</u> to stabilize without human assistance 2. Not steady, <u>only able</u> to stabilize with human assistance 8. Activity did not occur	<input type="checkbox"/> A. Moving from seated to standing position
	<input type="checkbox"/> B. Walking (with assistive device if used)
	<input type="checkbox"/> C. Turning around and facing the opposite direction while walking
	<input type="checkbox"/> D. Moving on and off toilet
	<input type="checkbox"/> E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

Definitions

Interdisciplinary Team (IDT) – Refers to a team from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners. In a community setting the IDT may also include, HMO service coordinator, the individual, the HCSSA representative, etc.

Unsteady – Individuals may appear unbalanced or move with a sway or with uncoordinated or jerking movements that make them unsteady. They might exhibit unsteady gaits such as fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide based gaits with halting, tentative steps.

Item Rationale

Health-related Quality of Life

- Individuals with impaired balance and unsteadiness during transitions and walking
 - Are at increased risk for falls;
 - Often are afraid of falling;
 - May limit their physical and social activity, becoming socially isolated and despondent about limitations; and
 - Can become increasingly immobile.

Planning for Care

- Individuals with impaired balance and unsteadiness should be evaluated for the need for
 - Rehabilitation or assistive devices;
 - Supervision or physical assistance for safety; and/or
 - Environmental modification.
- Care planning should focus on preventing further decline of function, and/or on return of function, depending on individual-specific goals.
- Assessment should identify all related risk factors in order to develop effective care plans to maintain current abilities, slow decline, and/or promote improvement in the individual's functional ability.

Steps for Assessment

1. Complete this assessment for all individuals.
2. If caregivers have not systematically documented the individual's stability during transition from sitting to standing, walking, turning, transferring on and off toilet, and transferring from wheelchair to bed and bed to wheelchair at least once during the 7-day look-back period, use the following process to code these items:
 - Before beginning the activity, explain what the task is and what you are observing for.
 - Have assistive devices the individual normally uses available.
 - Start with the individual sitting up on the edge of his or her bed, in a chair or in a wheelchair (if he or she generally uses one).
 - Ask the individual to stand up and stay still for 3-5 seconds. **Moving from seated to standing position (G0300A) should be rated at this time.**
 - Ask the individual to walk approximately 15 feet using his or her usual **assistive device. Walking (G0300B) should be rated at this time.**
 - Ask the individual to turn around. **Turning around (G0300C) should be rated at this time.**
 - Ask the **individual to walk or wheel** from a starting point in his or her home into the bathroom, **prepare for toileting** as he or she normally does (including taking down pants or other clothes; underclothes can be kept on for this observation), and sit on the toilet. **Moving on and off toilet (G0300D) should be rated at this time.**
 - Ask individuals who are not ambulatory and who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed. **Surface-to-surface transfer should be rated at this time (G0300E).**

Coding Instructions G0300A, Moving from Seated to Standing Position

Code for the least steady episode observed by the nurse assessor or reported by the caregiver using assistive device if applicable.

- **Code 0, steady at all times:**
 - If all of the transitions from seated to standing position and from standing to seated position observed during the 7-day look-back period are steady.
 - If individual is stable when standing up using the arms of a chair or an assistive device identified for this purpose (such as a walker, locked wheelchair, or grab bar).
 - If an assistive device or equipment is used, the individual appropriately plans and integrates the use of the device into the transition activity.
 - If individual appears steady and not at risk of a fall when standing up.
- **Code 1, not steady, but able to stabilize without caregivers assistance:**
 - If any of transitions from seated to standing position or from standing to seated position during the 7-day look-back period are not steady, but the individual is able to stabilize without assistance from caregivers or object (e.g., a chair or table).
 - If the individual is unsteady using an assistive device but does not require caregivers assistance to stabilize.
 - If the individual attempts to stand, sits back down, and then is able to stand up and stabilizes without assistance from caregivers or object.

- Individuals coded in this category appear at increased risk for falling when standing up.
- **Code 2, not steady, only able to stabilize with caregivers assistance:**
 - If any of transitions from seated to standing or from standing to sitting are not steady, and the individual cannot stabilize without assistance from caregivers.
 - If the individual cannot stand but can transfer unassisted without caregivers assistance.
 - If the individual returned back to a seated position or was unable to move from a seated to a standing or from standing to sitting position during the look-back period.
 - Individuals coded in this category appear at high risk for falling during transitions.
 - If a lift device (a mechanical device operated by another person) is used because the individual requires caregiver assistance to stabilize, code as 2.
- **Code 8, activity did not occur:** if the individual did not move from seated to standing position during the 7-day look-back period.

Examples for G0300A, Moving from Seated to Standing Position

1. Ms. F sits up in bed, stands, and begins to sway, but steadies herself and sits down smoothly into her wheelchair.

Coding: G0300A would be **coded 1, not steady, but able to stabilize without caregivers assistance.**

Rationale: She was unsteady, but she was able to stabilize herself without assistance from caregivers.

2. Mr. Z requires the use of a gait belt and physical assistance in order to stand.

Coding: G0300A would be **coded 2, not steady, only able to stabilize with caregiver assistance.**

Rationale: He required caregiver assistance to stand during the observation period.

3. Mr. W stands steadily by pushing himself up using the arms of a chair.

Coding: G0300A would be **coded 0, steady at all times.**

Rationale: Even though he used the arms of the chair to push himself up, he was steady at all times during the activity.

4. Mr. C locks his wheelchair and uses the arms of his wheelchair to attempt to stand. On the first attempt, he rises about halfway to a standing position then sits back down. On the second attempt, he is able to stand steadily.

Coding: G0300A would be **coded 1, not steady, but able to stabilize without caregivers assistance.**

Rationale: Even though the second attempt at standing was steady, the first attempt suggests he is unsteady and at risk for falling during this transition.

Coding Instructions G0300B, Walking (with Assistive Device if Used)

Code for the least steady episode observed by the nurse assessor or reported by the caregiver using assistive device if applicable.

- **Code 0, steady at all times:**
 - If during the 7-day look-back period the individual's walking (with assistive devices if used) is steady at all times.
 - If an assistive device or equipment is used, the individual appropriately plans and integrates the use of the device and is steady while walking with it.
 - Individuals in this category do not appear at risk for falls.
 - Individuals who walk with an abnormal gait and/or with an assistive device can be steady, and if they are they should be coded in this category.
- **Code 1, not steady, but able to stabilize without caregiver assistance:**
 - If during the 7-day look-back period the individual appears unsteady while walking (with assistive devices if used) but does not require caregiver assistance to stabilize.
 - Individuals coded in this category appear at risk for falling while walking.
- **Code 2, not steady, only able to stabilize with caregiver assistance:**
 - If during the 7-day look-back period the individual at any time appeared unsteady and required caregivers assistance to be stable and safe while walking.
 - If the individual fell when walking during the look-back period.
 - Individuals coded in this category appear at high risk for falling while walking.
- **Code 8, activity did not occur:**
 - If the individual did not walk during the 7-day look-back period.

Examples for G0300B, Walking (with Assistive Device if Used)

1. Ms. H with a recent stroke walks using a hemi-walker in her right hand because of left-sided weakness. Her gait is slow and short-stepped and slightly unsteady as she walks, she leans to the left and drags her left foot along the ground on most steps. She has not had to steady herself using any furniture or grab bars.

Coding: G0300B would be **coded 1, not steady, but able to stabilize without caregiver assistance.**

Rationale: Her gait is unsteady with or without an assistive device but does not require caregiver assistance.

2. Mr. B with Parkinson's disease ambulates with a walker. His posture is stooped, and he walks slowly with a short-stepped shuffling gait. On some occasions, his gait speeds up, and it appears he has difficulty slowing down. On multiple occasions during the 7-day observation period he has to steady himself using a handrail or a piece of furniture in addition to his walker.

Coding: G0300B would be coded **1, not steady, but able to stabilize without caregiver assistance.**

Rationale: He has an unsteady gait but can stabilize himself using an object such as a handrail or piece of furniture.

3. Ms. M who had a recent total hip replacement ambulates with a walker. Although she is able to bear weight on her affected side, she is unable to advance her walker safely without caregiver assistance.

Coding: G0300B would be coded **2, not steady, only able to stabilize with caregiver assistance.**

Rationale: She requires caregiver assistance to walk steadily and safely at any time during the observation period.

4. Ms. O with multi-infarct dementia walks with a short-stepped, shuffling-type gait. Despite the gait abnormality, she is steady.

Coding: G0300B would be coded **0, steady at all times.**

Rationale: She walks steadily (with or without a normal gait and/or the use of an assistive device) at all times during the observation period.

Pediatric Tip

A toddler is just learning to walk; or a child needs assistance to walk-

Coding: G0300B would be coded 2, not steady, only able to stabilize with human assistance.

Coding Instructions G0300C, Turning Around and Facing the Opposite Direction while Walking

Code for the least steady episode observed by the nurse assessor or reported by the caregiver using assistive device if applicable.

- **Code 0, steady at all times:**
 - If all turns to face the opposite direction are steady without assistance of a caregiver during the 7-day look-back period.
 - If the individual is stable making these turns when using an assistive device.
 - If an assistive device or equipment is used, the individual appropriately plans and integrates the use of the device into the transition activity.
 - Individuals coded as 0 should not appear to be at risk of a fall during a transition.
- **Code 1, not steady, but able to stabilize without caregiver assistance:**
 - If any transition that involves turning around to face the opposite direction is not steady, but the individual stabilizes without assistance from a caregiver.
 - If the individual is unstable with an assistive device but does not require caregivers assistance.
 - Individuals coded in this category appear at increased risk for falling during transitions.

- **Code 2, not steady, only able to stabilize with caregiver assistance:**
 - If any transition that involves turning around to face the opposite direction is not steady, and the individual cannot stabilize without assistance from a caregiver.
 - If the individual fell when turning around to face the opposite direction during the look-back period.
 - Individuals coded in this category appear at high risk for falling during transitions.
- **Code 8, activity did not occur:**
 - If the individual did not turn around to face the opposite direction while walking during the 7-day look-back period.

Examples for G0300C, Turning Around and Facing the Opposite Direction while Walking

1. Mr. Z with Alzheimer’s disease frequently wanders. On one occasion, a caregiver noted that he was about to fall when turning around. However, by the time she got to him, he had steadied himself on the handrail.

Coding: G0300C would be **coded 1, Not steady, but able to stabilize without caregiver assistance.**

Rationale: He was unsteady when turning but able to steady himself on an object, in this instance, a handrail.

2. Ms. V with severe arthritis in her knee ambulates with a single-point cane. A caregiver observes her lose her balance while turning around to sit in a chair. The caregiver is able to get to her before she falls and lowers her gently into the chair.

Coding: G0300C would be **coded 2, not steady, only able to stabilize with caregiver assistance.**

Rationale: She was unsteady when turning around and would have fallen without caregiver assistance.

Coding for G0300D, Moving on and off Toilet

Code for the least steady episode of moving on and off a toilet or portable commode, observed by nurse or reported by caregiver, using an assistive device if applicable. Include stability while manipulating clothing to allow toileting to occur in this rating.

- **Code 0, steady at all times:**
 - If all of the transitions on and off the toilet during the 7-day look-back period are steady without assistance of a caregiver.
 - If the individual is stable when transferring using an assistive device or object identified for this purpose.
 - If an assistive device is used (e.g., a handrail, the planned use of the sink), the individual appropriately plans and integrates the use of the device into the transition activity.
 - Individuals coded as 0 should not appear to be at risk of a fall during a transition.
- **Code 1, not steady, but able to stabilize without caregiver assistance:**
 - If any transitions on or off the toilet during the 7-day look-back period are not steady, but

the individual stabilizes without assistance from a caregivers.

- If individual is unstable with an assistive device but does not require caregiver assistance.
- Individuals coded in this category appear at increased risk for falling during transitions.

- **Code 2, not steady, only able to stabilize with caregiver assistance:**

- If any transitions on or off the toilet during the 7-day look-back period are not steady, and the individual cannot stabilize without assistance from a caregivers.
- If the individual fell when moving on or off the toilet during the look-back period.
- If lift device is used.
- Individuals coded in this category appear at high risk for falling during transitions.

- **Code 8, activity did not occur:**

- If the individual did not transition on and off the toilet during the 7-day look-back period.

Examples for G0300D, Moving on and off Toilet

1. Ms. T sits up in bed, stands up, pivots and grabs her walker. She then steadily walks to the bathroom where she pivots, pulls down her underwear, uses the grab bar and smoothly sits on the commode using the grab bar to guide her. After finishing, she stands and pivots using the grab bar and smoothly ambulates out of her room with her walker.

Coding: G0300D would be **coded 0, steady at all times.**

Rationale: Her use of the grab bar was not to prevent a fall after being unsteady, but to maintain steadiness during her transitions. The individual was able to smoothly and steadily transfer onto the toilet, using a grab bar.

2. Ms. H wheels her wheelchair into the bathroom, stands up, begins to lift her dress, sways, and grabs onto the grab bar to steady herself. When she sits down on the toilet, she leans to the side and must push herself away from the towel bar to sit upright steadily.

Coding: G0300D would be **coded 1, not steady, but able to stabilize without caregiver assistance.**

Rationale: She was unsteady when disrobing to toilet but was able to steady herself with a grab bar.

3. Mr. Y wheels his wheelchair into the bathroom, stands, begins to pull his pants down, sways, and grabs onto the grab bar to steady himself. When he sits down on the toilet, he leans to the side and must push himself away from the sink to sit upright steadily. When finished, he stands, sways, bumps into the wall, and then is able to steady himself with the grab bar.

Coding: G0300D would be **coded 1, not steady, but able to stabilize without caregiver assistance.**

Rationale: He was unsteady when disrobing to toilet but was able to steady himself with a grab bar.

Coding Instructions G0300E, Surface-to-Surface Transfer (Transfer between Bed

and Chair or Wheelchair)

Code for the least steady episode observed by the nurse assessor or reported by the caregiver.

- **Code 0, steady at all times:**
 - If all of the transfers during the 7-day look-back period are steady without assistance of a caregiver.
 - If the individual is stable when transferring using an assistive device identified for this purpose.
 - If an assistive device or equipment is used, the individual uses it independently and appropriately plans and integrates the use of the device into the transition activity.
 - Individuals **coded 0** should not appear to be at risk of a fall during a transition.
- **Code 1, not steady, but able to stabilize without caregiver assistance:**
 - If any transfers during the look-back period are not steady, but the individual stabilizes without assistance from a caregiver.
 - If the individual is unstable with an assistive device but does not require caregivers assistance.
 - Individuals coded in this category appear at increased risk for falling during transitions.
- **Code 2, not steady, only able to stabilize with caregiver assistance:**
 - If any transfers during the 7-day look-back period are not steady, and the individual can only stabilize with assistance from a caregivers.
 - If the individual fell during a surface-to-surface transfer during the look-back period.
 - Individuals coded in this category appear at high risk for falling during transitions.
 - If a lift device (a mechanical device that is completely operated by another person) is used, and this mechanical device is being used because the individual requires caregivers assistance to stabilize, code 2.
- **Code 8, activity did not occur:**
 - If the individual did not transfer from bed to wheelchair/chair or wheelchair/chair to bed during the 7-day look-back period.

Examples for G0300E, Surface-to-Surface Transfer (Transfer between Bed and Chair or Wheelchair)

1. Ms. A. who uses her wheelchair for mobility stands up from the edge of her bed, pivots, and sits in her locked wheelchair in a steady fashion.

Coding: G0300E would be **coded 0, steady at all times.**

Rationale: She was steady when transferring from bed to wheelchair.

2. Mr. I who needs assistance ambulating transfers to his chair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a caregiver helps him stand up straight, pivot, and sit down in his chair.

Coding: G0300E would be **coded 2, not steady, only able to stabilize with caregiver assistance.**

Rationale: He was unsteady when transferring from bed to wheelchair and required caregiver

assistance to make a steady transfer.

3. Mr. X with an above-the-knee amputation sits on the edge of the bed and, using his locked wheelchair due to unsteadiness and the nightstand for leverage, stands and transfers to his wheelchair rapidly and almost misses the seat. He is able to steady himself using the nightstand and sit down into the wheelchair without falling to the floor.

Coding: G0300E would be coded **1, not steady, but able to stabilize without caregiver assistance.**

Rationale: He was unsteady when transferring from bed to wheelchair but did not require caregiver assistance to complete the activity.

4. Ms. Q who uses her wheelchair for mobility stands up from the edge of her bed, sways to the right, but then is quickly able to pivot and sits in her locked wheelchair in a steady fashion.

Coding: G0300E would be coded **1, not steady, but able to stabilize without caregiver assistance.**

Rationale: She was unsteady when transferring from bed to wheelchair but was able to steady herself without caregiver assistance or an object.

Additional example for G0300A-E, Balance during Transitions and Walking

1. Ms. U sits up in bed, stands up, pivots and sits in her locked wheelchair. She then wheels her chair to the bathroom where she stands, pivots, lifts gown and smoothly sits on the commode.

Coding: G0300A, G0300D, G0300E would be coded **0, steady at all times.**

Rationale: She was steady during each activity.

G0400: Functional Limitation in Range of Motion

G0400. Functional Limitation in Range of Motion	
Code for limitation that interfered with daily functions or placed individual at risk of injury	
Coding:	↓ Enter Codes in Boxes
0. No impairment	<input type="checkbox"/> A. Upper extremity (shoulder, elbow, wrist, hand)
1. Impairment on one side	
2. Impairment on both sides	<input type="checkbox"/> B. Lower extremity (hip, knee, ankle, foot)

Definition

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

1. Review the medical record, if available, for references to functional range of motion limitation during the 7-day look-back period.
2. Talk with caregivers who work with the individual as well as family/significant others about any impairment in functional ROM.
3. Assess the individual's ROM at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).
4. Assess both sides of the individual's body.
5. Depending on the individual's cognitive level, use the direction most appropriate for assessing limitations in ROM such as:
 - Asking the individual to follow your verbal instructions for each movement.
 - Demonstrating each movement (e.g., ask the individual to do what you are doing).
 - Actively assisting the individual with ROM exercises.
6. Caregiver observations of the ROM activity can be used to determine whether or not an individual can actually perform the activity, regardless of whether or not the movement was "on command," provided the movement fits the criteria specified and occurred during the 7-day look-back period.

Coding Instructions for: G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand) G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

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

Coding Tips

Do not look at limited ROM in isolation. You must determine if the limited ROM impacts functional ability or places the individual at risk for injury. For example, if the individual has an amputation it does not automatically mean that they are limited in function. He/she may not have a particular joint in which certain range of motion can be tested, however, it does not mean that

the individual with an amputation has a limitation in completing ADLs, nor does it mean that the individual is automatically at risk of injury. There are many individuals with amputations who function extremely well and can complete all ADLs either with or without the use of prosthetics. If the individual with an amputation does indeed have difficulty completing ADLs and is at risk for injury, this should be coded as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.

Examples

- Ms. Y can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand and leg motion) as she has a flaccid left hemiparesis.

Coding: G0400A would be **coded 1, upper extremity impairment on one side** G0400B would be **coded 1, lower extremity impairment on one side**

Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side.

- Ms. E had shoulder surgery and can't brush her hair or raise her right arm above her head. The individual has no impairment on the lower extremities.

Coding: G0400A would be **coded 1, upper extremity impairment on one side** G0400B would be **coded 0, no impairment**

Rationale: Impairment due to shoulder surgery affects only one side of her upper extremities.

- Mr. O has a diagnosis of Parkinson's and ambulates with a shuffling gate. The individual has had 3 falls in the past quarter and often forgets his walker which he needs to ambulate. He has tremors of both upper extremities that make it very difficult to feed himself, brush his teeth or write.

Coding: G0400A would be **coded 2, upper extremity impairment on both sides** G0400B would be **coded 2, lower extremity impairment on both sides**

Rationale: Impairment due to Parkinson's disease affects him at the upper and lower extremities on both sides.

G0600: Mobility Devices

G0600. Mobility Devices	
↓ Check all that were normally used	
<input type="checkbox"/>	A. Cane/crutch
<input type="checkbox"/>	B. Walker
<input type="checkbox"/>	C. Wheelchair (manual or electric)
<input type="checkbox"/>	D. Limb prosthesis
<input type="checkbox"/>	Z. None of the above were used

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Individual ability to move about may be directly related to the use of devices. It is critical that caregivers assure that the individual's independence is optimized by making available mobility devices on a daily basis, if needed.

Steps for Assessment

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

Coding Instructions

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

- **Check G0600A, cane/crutch:** if the individual used a cane or crutch, including single prong, tripod, quad cane, etc.
- **Check G0600B, walker:** if the individual used a walker or hemi-walker, including an enclosed frame-wheeled walker with/without a posterior seat and lap cushion. Also check this item if the individual walks while pushing a wheelchair for support.
- **Check G0600C, wheelchair (manual or electric):** if the individual normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person.
- **Check G0600D, limb prosthesis:** if the individual used an artificial limb to replace a missing extremity.
- **Check G0600Z, none of the above were used:** if the individual used none of the mobility devices listed in G0600 or locomotion did not occur during the look-back period.

Pediatric Tip

For children with mobility problems a stroller may be coded in G0600 instead of a wheelchair if that is the device used.

Examples

- Ms. L uses a quad cane daily to walk in the home or community setting. She uses a standard push wheelchair that she self-propels when leaving the home or community setting due to her issues with endurance.

Coding: G0600A, use of cane/crutch, and G0600C, wheelchair, would be checked
Rationale: She uses a quad cane in her room and a wheelchair outside of her room.

- Mr. J has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied he is able to ambulate independently.

Coding: G0600D, limb prosthesis, would be checked
Rationale: He uses a leg prosthesis for ambulating.

G0900: Functional Rehabilitation Potential

Complete only on initial assessment.

G0900. Functional Rehabilitation Potential	
Complete only if A0310A = 01	
Enter Code <input type="text"/>	A. Individual believes he or she is capable of increased independence in at least some ADLs 0. No 1. Yes 9. Unable to determine
Enter Code <input type="text"/>	B. Caregiver believes individual is capable of increased independence in at least some ADLs 0. No 1. Yes -. No information/not assessed

Item Rationale

Health-related Quality of Life

- Attaining and maintaining independence is important to an individual's feelings of autonomy and self-worth.
- Independence is also important to health status, as decline in function can trigger all of the complications of immobility, depression, and social isolation.

Planning for Care

- Beliefs held by the individual and caregivers that the individual has the capacity for greater independence and involvement in self-care in at least some ADL areas may be important clues to assist in setting goals.
- Even if highly independent in an activity, the individual or caregivers may believe the individual can gain more independence (e.g., walk longer distances, shower independently).
- Disagreement between caregiver's beliefs and individual beliefs should be explored by the interdisciplinary team.

Steps for Assessment: Interview Instructions for G0900A, Individual Believes He

or She Is Capable of Increased Independence in at Least Some ADLs

1. Ask if the individual thinks he or she could be more self-sufficient given more time.
2. Listen to and record what the individual believes, even if it appears unrealistic.
3. It is sometimes helpful to have a conversation with the individual that helps him/her break down this question. For example, you might ask the individual what types of things caregivers assist him with and how much of those activities the caregivers do for the individual. Then ask the individual, “Do you think that you could get to a point where you do more or all of the activity yourself?”

Coding Instructions for G0900A, Individual Believes He or She Is Capable of Increased Independence in at Least Some ADLs

- **Code 0, no:** if the individual indicates that he or she believes he or she will probably stay the same and continue with his or her current needs for assistance.
- **Code 1, yes:** if the individual indicates that he or she thinks he or she can improve. Code even if the individual’s expectation appears unrealistic.
- **Code 9, unable to determine:** if the individual cannot indicate any beliefs about his or her functional rehabilitation potential.

Example for G0900A, Individual Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Mr. N is cognitively impaired and receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when the caregiver is not looking.

Coding: G0900A would be coded **1, yes**

Rationale: He believes he is capable of increased independence.

Steps for Assessment for G0900B, Caregiver Believes Individual Is Capable of Increased Independence in at Least Some ADLs

1. Discuss with the interdisciplinary team if service delivery is affected.
2. Ask caregivers who routinely care for or work with the individual if they think he or she is capable of greater independence in at least some ADLs.

Coding Instructions for G0900B, Caregiver Believes Individual Is Capable of Increased Independence in at Least Some ADLs

- **Code 0, no:** if caregivers believe the individual probably will stay the same and continue with current needs for assistance. Also **code 0** if caregivers believe the individual is likely to experience a decrease in his or her capacity for ADL care performance.

- **Code 0, no** if no caregiver is available to respond to this question. Explain in S10, Comments.
- **Code 1, yes:** if caregivers believe the individual can gain greater independence in ADLs or if caregivers indicate they are not sure about the potential for improvement, because that indicates some potential for improvement.

Example for G0900B, Caregiver Believes Individual Is Capable of Increased Independence in at Least Some ADLs

1. The caregiver who totally feeds Mrs. W. has noticed in the past week that Mrs. W. has made several attempts to pick up finger foods. She believes Mrs. W. could become more independent in eating if she received close supervision and cueing.

Coding: G0900B would be **coded 1, yes**

Rationale: Based upon observation of the individual, the caregiver believes Mrs. W. is capable of increased independence.

SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each individual who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.

H0100: Appliances

Section H	Bladder and Bowel
H0100. Appliances	
↓ Check all that apply	
<input type="checkbox"/>	A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)
<input type="checkbox"/>	B. External catheter
<input type="checkbox"/>	C. Ostomy (including urostomy, ileostomy, and colostomy)
<input type="checkbox"/>	D. Intermittent catheterization
<input type="checkbox"/>	Z. None of the above

Definitions

Indwelling Catheter - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

Suprapubic Catheter - An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.

Nephrostomy Tube - A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.

External Catheter - Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.

Ostomy - Any type of surgically created opening of the gastrointestinal or gastrourinary tract for discharge of body waste.

Urostomy - A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

Ileostomy - A stoma that has been created by bringing the end or loop of the small intestine (the ileum) out onto the surface of the skin.

Colostomy - A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

Intermittent catheterization - Sterile insertion and removal of a catheter through the urethra for bladder drainage. This includes self- catheterization using clean technique.

Item Rationale

Health-related Quality of Life

- It is important to know what appliances are in use and the history and rationale for such use.
- External catheters should fit well and be comfortable, minimize leakage, maintain skin integrity, and promote individual dignity.
- Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.
- Ostomies (and peristomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote individual dignity.

Planning for Care

- Planning for care should include interventions that are consistent with the individual's goals and minimize complications associated with appliance use.
- Planning for care should be based on an assessment and evaluation of the individual's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, individual's overall condition, risk factors and information about the individual's continence status, catheter status, environmental factors related to continence programs, and the individual's response to catheter/continence services.

Steps for Assessment

1. Examine the individual to note the presence of any urinary or bowel appliances.
2. Review the medical record, if available, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

*Check next to each appliance that was used at any time in the past 7 days. Select **none of the above** if none of the appliances A-D were used in the past 7 days.*

- **H0100A**, indwelling catheter (including suprapubic catheter and nephrostomy tube)
- **H0100B**, external catheter
- **H0100C**, ostomy (including urostomy, ileostomy, and colostomy)
- **H0100D**, intermittent catheterization
- **H0100Z**, none of the above

Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- In men, condom catheters, and in females, external urinary pouches, are commonly used intermittently or at night only. This use should be coded as external catheter.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterization for urine specimen during the look-back period as intermittent catheterization

H0200: Urinary Toileting Program ®

H0200. Urinary Toileting Program	
Enter <input type="checkbox"/> Code	C. Current continence promotion program or trial – Is an individualized continence promotion program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the individual's urinary continence? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- An individualized, toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- Determining the type of urinary incontinence can allow caregivers to provide more individualized programming or interventions to enhance the individual's quality of life and functional status.
- Many incontinent individuals (including those with dementia) respond to a toileting program, especially during the day.

Planning for Care

- The steps toward ensuring that the individual receives appropriate treatment and services to restore as much bladder function as possible are:
 - Determining if the individual is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
 - Completing an accurate, thorough assessment of factors that may predispose the individual to having urinary incontinence; and
 - Implementing appropriate, individualized interventions and modifying them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one quarter to one third of individuals will have a decrease or resolution of incontinence in response to a toileting program.
- Individuals may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.

Definitions

Bladder Rehabilitation/Bladder Retraining - A behavioral technique that requires the individual to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than the urge to void.

Prompted Voiding - Prompted voiding includes (1) regular monitoring with encouragement to report consistence status, (2) using a schedule and prompting the individual to toilet, and (3) praise and positive feedback when the individual is continent and attempts to toilet.

Habit Training/Scheduled Voiding - A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the individual's voiding habits or needs.

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record, if available, or ask the caregiver for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. The following **three requirements** must have been met:
 - implementation of an individualized, individual-specific toileting program that was based on an assessment of the individual's unique voiding pattern
 - evidence that the individualized program was communicated to the caregiver and the individual (as appropriate) verbally and through a care plan, flow records, and a written report
 - notations of the individual's response to the toileting program and subsequent evaluations, as needed

Coding Instructions H0200C, Current Toileting Program

- **Code 0, no:** if an individualized toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) is used less than 4 days of the 7-day look-back period to manage the individual's urinary continence.
- **Code 1, yes:** for individuals who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some individuals prefer to not be awakened to toilet. If that individual, however, is on a toileting program during the day, code "yes."

Coding Tips for H0200C

- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with current standards of practice. A toileting program does not refer to:
 - Simply tracking continence status,
 - Changing pads or wet garments, and
 - Random assistance with toileting or hygiene.

- For an individual currently undergoing a trial of a toileting program, H0200C would be **coded 1, current toileting program.**

Example

1. Mrs. H. has a diagnosis of advanced Alzheimer’s disease. She is dependent on the caregiver for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding assessment/diary indicates no pattern to her incontinence.

Coding: H0200C would be coded as 0, no

Rationale: Since she has impaired cognition with no pattern to her voiding and did not respond to a toileting program, caregiver will provide supportive care.

H0300: Urinary Continence

H0300. Urinary Continence	
Enter <input type="text"/> Code	Urinary continence – Select the one category that best describes the individual 0. Always continent 1. Occasionally incontinent (less than 7 episodes of incontinence) 2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. Always incontinent (no episodes of continent voiding) 9. Not rated, individual had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 7 days

Definitions

Urinary Incontinence - The involuntary loss of urine.

Continence - Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

Item Rationale

Health-related Quality of Life

- Incontinence can:
 - Interfere with participation in activities,
 - Be socially embarrassing and lead to increased feelings of dependency,
 - Increase risk of long-term institutionalization,
 - Increase risk of skin rashes and breakdown,
 - Increased risk of repeated urinary tract infections, and
 - Increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many individuals, incontinence can be resolved or minimized by
 - Identifying and treating underlying potentially reversible causes, including medication

- side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence);
 - Eliminating environmental physical barriers to accessing commodes, bedpans, and urinals; and
 - Bladder retraining, prompted voiding, or scheduled toileting.
- For individuals whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, there should be a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination, if available.
2. Interview the individual if he or she is capable of reliably reporting his or her continence.
3. Ask the caregiver if the individual has incontinence episodes.

Coding Instructions

- **Code 0, always continent:** if throughout the 7-day look-back period the individual has been continent of urine, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the individual was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the individual was incontinent of urine during 7 or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.
- **Code 3, always incontinent:** if during the 7-day look-back period, the individual had no continent voids.
- **Code 9, not rated:** if during the 7-day look-back period the individual had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

Coding Tips and Special Populations

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

Pediatric Tip

- Code “3” always incontinent for an infant or toddler who is incontinent of urine even though it is age appropriate.

Examples

1. Mrs. R an 86-year-old female has had longstanding stress-type incontinence for many years.

When she has an upper respiratory infection and is coughing, she involuntarily loses urine. However, during the current 7-day look-back period, she has been free of respiratory symptoms and has not had an episode of incontinence.

Coding: H0300 would be **coded 0, always continent**

Rationale: Even though she has known intermittent stress incontinence, she was continent during the current 7-day look-back period.

- 2 Mr. G with multi-infarct dementia is incontinent of urine on three occasions on day one of observation, continent of urine in response to toileting on days two and three, and has one urinary incontinence episode during each of the nights of days four, five, six, and seven of the look-back period.

Coding: H0300 would be **coded as 2, frequently incontinent.**

Rationale: He had seven documented episodes of urinary incontinence over the look-back period. The criterion for “frequent” incontinence has been set at seven or more episodes over the 7-day look-back period with at least one continent void.

- 3 Mr. V with Parkinson’s disease is severely immobile, and cannot be transferred to a toilet. He is unable to use a urinal and is managed by adult briefs and bed pads that are regularly changed. He did not have a continent void during the 7-day look-back period.

Coding: H0300 would be **coded as 3, always incontinent.**

Rationale: He has no urinary continent episodes and cannot be toileted due to severe disability or discomfort. He had one continent urinary void during the 7-day look-back period, after the caregiver assisted him to the toilet and helped with clothing. All other voids were incontinent.

H0400: Bowel Continence

H0400. Bowel Continence	
Enter <input type="text"/> Code	Bowel continence – Select the one category that best describes the individual 0. Always continent 1. Occasionally incontinent (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. Always incontinent (no episodes of continent bowel movements) 9. Not rated , individual had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
 - Interfere with participation in activities,
 - Be socially embarrassing and lead to increased feelings of dependency,
 - Increase risk of long-term institutionalization,
 - Increase risk of skin rashes and breakdown, and
 - Increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many individuals, incontinence can be resolved or minimized by
 - Identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence); and
 - Eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.
- For individuals whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record, if available, for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination, if available.
2. Interview the individual if he or she is capable of reliably reporting his or her bowel habits.
3. Ask the caregiver if the individual has incontinence episodes.

Coding Instructions

- **Code 0, always continent:** if during the 7-day look-back period the individual has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the individual was incontinent of stool once. This includes incontinence of any amount of stool day or night.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the individual was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
- **Code 3, always incontinent:** if during the 7-day look-back period, the individual was incontinent of bowel for all bowel movements and had no continent bowel movements.
- **Code 9, not rated:** if during the 7-day look-back period the individual had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these individuals should be checked for fecal impaction and evaluated for constipation.)

Coding Tips and Special Populations

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Pediatric Tip

- Code “3” always incontinent for an infant or toddler who is incontinent of stool even though it is age appropriate.

H0500: Bowel Continence Program ®

H0500. Bowel Continence Program	
Enter <input type="checkbox"/> Code	Is an individualized continence promotion program currently being used to manage the individual's bowel continence? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences of incontinence.
- Many incontinent individuals respond to a bowel toileting program, especially during the day.

Planning for Care

- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Individuals who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management.
- Individuals with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program the provider/caregiver may want to consider assessing the individual for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement (Newman, 2009).

Steps for Assessment

- 1 Review the medical record, if available, for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
- 2 The following **three requirements** must have been met:
 - Implementation of an individualized, individual-specific bowel toileting program based on an assessment of the individual's unique bowel pattern;
 - Evidence that the individualized program was communicated to the caregiver and the individual (as appropriate) verbally and, if available, through a care plan, flow records, written report; and
 - Notations of the individual's response to the toileting program and subsequent evaluations.

H0600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code <input type="checkbox"/>	Constipation present? 0. No 1. Yes

Coding Instructions

- **Code 0, no:** if the individual is not currently on a toileting program targeted specifically at managing bowel continence.
- **Code 1, yes:** if the individual is currently on a toileting program targeted specifically at managing bowel continence.

Definitions

Constipation - If the individual has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).

Fecal Impaction - A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the individual may be unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of impaction.

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies individuals who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as:
 - Dehydration due to a medical condition or inadequate access to and intake of fluid, and
 - Side effect of medications.

Steps for Assessment

1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, and physical examination, if available, to determine if the individual has had problems with constipation during the 7-day look-back period.
2. Individuals who are capable of reliably reporting their continence and bowel habits should be interviewed.

3. Ask caregivers who routinely work with the individual about problems with constipation.

Coding Instructions

- **Code 0, no:** if the individual shows no fecal impaction or signs of constipation during the 7-day look-back period.
- **Code 1, yes:** if the individual shows signs of constipation or has a fecal impaction during the 7-day look-back period.

Coding Tips and Special Populations

Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

SECTION I: ACTIVE DIAGNOSES

Intent: The items in this section are intended to code diseases that have a direct relationship to the individual's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MN/LOC assessment is to generate an updated, accurate picture of the individual's current health status.

Active Diagnoses in the Last 7 Days

For UTI (I2300) only, the look-back period is 30 days.

Section I Active Diagnoses	
Active Diagnoses in the last 7 days – Check all that apply	
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists	
Cancer	
<input type="checkbox"/>	I0100. Cancer (with or without metastasis)
Heart/Circulation	
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
	I0799a. Blood Pressure <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/>	I0800. Orthostatic Hypotension
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	I0999. Peripheral Edema
Gastrointestinal	
<input type="checkbox"/>	I1100. Cirrhosis
<input type="checkbox"/>	I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
Genitourinary	
<input type="checkbox"/>	I1400. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/>	I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
<input type="checkbox"/>	I1550. Neurogenic Bladder
<input type="checkbox"/>	I1650. Obstructive Uropathy
Infections	
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
<input type="checkbox"/>	I2200. Tuberculosis
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
<input type="checkbox"/>	I2500. Wound Infection (other than foot)
Metabolic	
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
	I2999. Blood Sugar Range <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Active Diagnoses in the last 7 days – Check all that apply	
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists	
Musculoskeletal	
<input type="checkbox"/>	I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
<input type="checkbox"/>	I3800. Osteoporosis
<input type="checkbox"/>	I3900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
<input type="checkbox"/>	I3999. Contractures
<input type="checkbox"/>	I4000. Other Fracture
<input type="checkbox"/>	I4099. Scoliosis
Neurological	
<input type="checkbox"/>	I4200. Alzheimer's Disease
<input type="checkbox"/>	I4300. Aphasia
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	I4800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis
<input type="checkbox"/>	I5000. Paraplegia
<input type="checkbox"/>	I5100. Quadriplegia
<input type="checkbox"/>	I5199. Tremors
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)
<input type="checkbox"/>	I5250. Huntington's Disease
<input type="checkbox"/>	I5299. Muscular Dystrophy
<input type="checkbox"/>	I5300. Parkinson's Disease
<input type="checkbox"/>	I5350. Tourette's Syndrome
<input type="checkbox"/>	I5399. Hydrocephalus
<input type="checkbox"/>	I5400. Seizure Disorder or Epilepsy
I5499. Type of Seizure	
↓ Check all that apply	
<input type="checkbox"/>	A. Localized (partial or focal)
<input type="checkbox"/>	B. Generalized (absence, myclonic, clonic, tonic and atonic)
I5499C. Average Frequency of Seizures in the last 7 days	
Enter Code <input type="text"/>	0. No seizures
	1. Less than 1 seizure/week
	2. 1-6 seizures/week
	3. 1 seizure/day
	4. 2-5 seizures/day
	5. 6-12 seizures/day
<input type="checkbox"/>	6. More than 12 seizures/day
<input type="checkbox"/>	I5500. Traumatic Brain Injury (TBI)
<input type="checkbox"/>	I5599. Spina Bifida

Active Diagnoses in the last 7 days – Check all that apply	
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists	
Nutritional	
<input type="checkbox"/>	I5600. Malnutrition (protein or calorie) or at risk for malnutrition
<input type="checkbox"/>	I5699. At risk for dehydration
Psychiatric/Mood Disorder	
<input type="checkbox"/>	I5700. Anxiety Disorder
<input type="checkbox"/>	I5800. Depression (other than bipolar)
<input type="checkbox"/>	I5900. Manic Depression (bipolar disease)
<input type="checkbox"/>	I5950. Psychotic Disorder (other than schizophrenia)
<input type="checkbox"/>	I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)
<input type="checkbox"/>	I6100. Post Traumatic Stress Disorder (PTSD)
<input type="checkbox"/>	I6199. ADHD Syndrome
Pulmonary	
<input type="checkbox"/>	I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
<input type="checkbox"/>	I6299. Cystic Fibrosis
<input type="checkbox"/>	I6300. Respiratory Failure
Vision	
<input type="checkbox"/>	I6500. Cataracts, Glaucoma, or Macular Degeneration
None of Above	
<input type="checkbox"/>	I7900. None of the above active diagnoses within the last 7 days
Other	
<input type="checkbox"/>	I8000. Additional active diagnoses Enter diagnosis description and ICD code.
A. _____	<input type="text"/>
B. _____	<input type="text"/>
C. _____	<input type="text"/>
D. _____	<input type="text"/>
E. _____	<input type="text"/>
F. _____	<input type="text"/>
G. _____	<input type="text"/>
H. _____	<input type="text"/>
I. _____	<input type="text"/>
J. _____	<input type="text"/>

Definitions

Active Diagnoses – Physician-documented diagnoses that have a direct relationship to the individual’s functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Functional Limitations - Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.

Nursing Monitoring – Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

Item Rationale

Health-Related Quality of Life

Disease processes can have a significant adverse effect on an individual’s health status and quality of life.

Planning for Care

This section identifies active diseases and infections that drive the current plan of care.

Steps for Assessment

Diagnosis status: Active or Inactive status in a 7-day look-back period.

1. **Identify diagnoses:** Review the medical record, if available, for diagnoses
 - Medical record sources include progress notes, the most recent history and physical transfer documents, discharge summaries, diagnosis/problem list, and other resources as available.
2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active**. Active diagnoses are diagnoses that have a direct relationship to the individual’s current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the individual’s current status, or do not drive the plan of care during the 7-day look-back period, as these would be considered inactive diagnosis. Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. For specific coding instructions for Item I2300 UTI please refer to coding tips under Active Diagnoses.
 - **Active** diagnoses have a **direct** relationship to the individual’s functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period.

Coding Instructions

Code diseases that have a documented diagnosis in the last 7 days and have a relationship to the individual's functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300, UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, for specific coding instructions).

- Document active diagnoses on the MN/LOC as follows:
 - Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision.
 - Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, **I0200, Anemia**, includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell).
- Check off each active disease. Check all that apply.
- If a disease or condition is **not** specifically listed, enter the ICD code for that diagnosis in item I8000, Additional active diagnoses, and the diagnosis name will auto-fill.
- ICD codes should be “right justified” (aligned with the right margin so that any unused boxes are on the left).
- If a diagnosis is a Z-code, another diagnosis for the related primary medical condition should be checked in items I7900 or entered in I8000.

Cancer

- **I0100**, cancer (with or without metastasis)

Heart/Circulation

- **I0200**, anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- **I0300**, atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
- **I0400**, coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])
- **I0500**, deep venous thrombosis (DVT), pulmonary embolus (PE), or pulmonary thromboembolism (PTE)
- **I0600**, heart failure (e.g., congestive heart failure [CHF], pulmonary edema)
- **I0700**, hypertension - If I0700 is checked
 - If I0700 is checked, entries in I0799a (Blood Pressure Reading) is required. I0799a - The valid values for systolic are 000-300. The valid values for diastolic are 000-200.
- **I0800**, orthostatic hypotension
- **I0900**, peripheral vascular disease or peripheral arterial disease
- **I0999, peripheral edema**

Gastrointestinal

- **I1100**, cirrhosis
- **I1200**, gastroesophageal reflux disease (GERD) or ulcer/injury (e.g., esophageal, gastric, and peptic ulcer/injuries)
- **I1300**, Ulcerative colitis or Crohn's disease or inflammatory bowel disease

Genitourinary

- **I1400**, benign prostatic hyperplasia (BPH)
- **I1500**, renal insufficiency, renal failure, or end-stage renal disease (ESRD)
- **I1550**, neurogenic bladder
- **I1650**, obstructive uropathy

Infections

- **I1700**, multidrug resistant organism (MDRO)
- **I2000**, pneumonia ®
- **I2100**, septicemia ®
- **I2200**, tuberculosis
- **I2300**, urinary tract infection (UTI) (30-Day Look-back)
- **I2400**, viral hepatitis (e.g., hepatitis A, B, C, D, and E)
- **I2500**, wound infection (other than foot)

Metabolic

- **I2900**, diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy) ®
 - If I2900 is checked, I2999 (Blood Sugar Range) is required.
 - Valid values for I2999 are 000-999.
- **I2999**, blood sugar range
- **I3100**, hyponatremia
- **I3200**, hyperkalemia
- **I3300**, hyperlipidemia (e.g., hypercholesterolemia)
- **I3400**, thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

Musculoskeletal

- **I3700**, arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, rheumatoid arthritis [RA])
- **I3800**, osteoporosis
- **I3900**, hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g., subcapital fractures and fractures of the trochanter and femoral neck))
- **I3999**, contractures
- **I4000**, other fracture
- **I4099**, scoliosis

Neurological

- **I4200**, Alzheimer's disease
- **I4300**, aphasia ®
- **I4400**, cerebral palsy ®
- **I4500**, cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- **I4800**, Non-Alzheimer's dementia (e.g., Lewy-Body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases)
- **I4900**, hemiplegia or hemiparesis ®
- **I5000**, paraplegia
- **I5100**, quadriplegia ®
- **I5199**, tremors
- **I5200**, multiple sclerosis (MS) ®
- **I5250**, Huntington's disease
- **I5299**, muscular dystrophy
- **I5300**, Parkinson's disease
- **I5350**, Tourette's syndrome
- **I5399**, hydrocephalus
- **I5400**, seizure disorder or epilepsy
- **I5499 Type of Seizure**
 - Check all that apply
 - A. Localized (partial or focal)
 - B. Generalized (absence, myoclonic, clonic, tonic and atonic)
 - **I5499C. Average Frequency of Seizures in the last 7 days**
 - 0. No seizures
 - 1. Less than one seizure/week
 - 2. 1-6 seizures/week
 - 3. 1 seizure/day
 - 4. 2-5 seizures/day
 - 5. 6-12 seizures/day
 - 6. More than 12 seizures/day
- **I5500**, Traumatic Brain Injury (TBI)
- **I5599**, Spina Bifida

Nutritional

- **I5600**, malnutrition (protein or calorie) or at risk for malnutrition
- **I5699**, at risk for dehydration

Psychiatric/Mood Disorder

- **I5700**, anxiety disorder
- **I5800**, depression (other than bipolar)
- **I5900**, bipolar disorder

- **I5950**, psychotic disorder (other than schizophrenia)
- **I6000**, schizophrenia (e.g., schizoaffective and schizophreniform disorders)
- **I6100**, post-traumatic stress disorder (PTSD)
- **I6199** ADHD Syndrome

Pulmonary

- **I6200**, asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)
- **I6299** Cystic Fibrosis
- **I6300**, respiratory failure

Vision

- **I6500**, cataracts, glaucoma, or macular degeneration

None of Above

- **I7900**, none of the above active diagnoses within the past 7 days

Other

- **I8000**, additional active diagnoses

Coding Tips

Sexually Transmitted Disease Reporting- Texas Health & Safety Code § 81.103 prevents the reporting of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) information on the MN/LOC. Do **not** enter the following International Classification of Diseases, Clinical Modification (ICD-10-CM) codes:

- B20 – Human immunodeficiency virus [HIV] disease
- B97.35 – Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere
- O98.711 – Human immunodeficiency virus [HIV] disease complicating pregnancy, first trimester
- O98.712 – Human immunodeficiency virus [HIV] disease complicating pregnancy, second trimester
- O98.713 – Human immunodeficiency virus [HIV] disease complicating pregnancy, third trimester
- O98.719 – Human immunodeficiency virus [HIV] disease complicating pregnancy, unspecified trimester
- O98.72 – Human immunodeficiency virus [HIV] disease complicating childbirth
- O98.73 – Human immunodeficiency virus [HIV] disease complicating the puerperium
- R75 – Inconclusive laboratory evidence of human immunodeficiency virus [HIV]
- Z11.4 - Encounter for screening for human immunodeficiency virus [HIV]

- Z20.6 – Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
- Z21 – Asymptomatic human immunodeficiency virus [HIV] infection status
- Z71.7 – Human immunodeficiency virus [HIV] counseling

Texas does not prohibit the reporting of ICD-10 code Z83.0, family history of [HIV] disease. It was determined that noting the existence of a family member with the disease did not violate the confidentiality of an individual's HIV/AIDS status.

Section I8000 may be completed for other sexually transmitted diseases (STDs) that are not HIV or AIDS or related.

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MN/LOC.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.**
 - The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
 - For example, the physician documents that the individual has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.
- **The listing of a diagnosis/disease on an individual's medical record is not sufficient for determining active or inactive status. To determine if "arthritis" for example, is an active diagnosis, the nurse assessor would determine if during the 7 day look-back period there were functional limitations caused by the arthritis and treatment for the symptoms of arthritis.**
- **In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:**
 - Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor's orders, etc.
 - Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease. Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease. For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and plans of care, progress notes, etc.
 - Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects

in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

1. Listing a disease/diagnosis (e.g., arthritis) on the individual's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.
- **It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice.** For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease.
 - **Look-back period for UTI differs from other items, the look-back period is 30 days:**

Code UTI only if all the following are met

1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed practitioner as permitted by state law diagnosis of a UTI in last 30 days,
2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria),
3. "Significant laboratory findings" (The physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and
4. Current medication or treatment for a UTI in the last 30 days.

Regarding individuals with colonized MRSA, the Centers for Disease Control (CDC) provided the following information: A physician often prescribes empiric antimicrobial therapy for a suspected infection after a culture is obtained, but prior to receiving the culture results. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness of continuation of antimicrobial therapy. This should not be any different, even if the individual is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other microbial resistant organism.

Examples of Active Disease

1. Mr. B is prescribed hydrochlorothiazide for hypertension. He requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen. Physician progress note documents hypertension.

Coding: Hypertension item (I0700), would be **checked**.

Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

2. Warfarin is prescribed for Ms. D with atrial fibrillation to decrease the risk of embolic stroke. She requires monitoring for change in heart rhythm, for bleeding, and for anticoagulation.

Coding: Atrial fibrillation item (I0300), would be **checked**.

Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

3. Ms. L has a past history of healed peptic ulcer/injury is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer/injury disease (PUD) from NSAID treatment.

Coding: Arthritis item (I3700), would be **checked**.

Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that she has a history of a healed peptic ulcer/injury without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

4. Mr. H had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior. He is on aspirin and has physical therapy and occupational therapy three times a week. The physician's note 25 days ago lists stroke.

Coding: Cerebrovascular Vascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke item (I4500), would be **checked**.

Rationale: The physician note within the last 30 days indicates stroke, and he is receiving medication and therapies to manage continued symptoms from stroke.

Examples of Inactive Diagnoses (do not code)

1. Ms. P had pneumonia 2 months ago and has recovered completely with no residual effects and no continued treatment during the 7-day look-back period.

Coding: Pneumonia item (I2000), would **not be checked**.

Rationale: The pneumonia diagnosis would not be considered active because of her complete recovery and the discontinuation of any treatment during the look-back period.

2. The problem list includes a diagnosis of coronary artery disease (CAD). Mr. O had an angioplasty 3 years ago, is not symptomatic, and is not taking any medication for CAD.

Coding: CAD item (I0400), would **not be checked**.

Rationale: He has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

3. Mr. J fell and fractured his hip 2 years ago. At the time of the injury, the fracture was surgically repaired. Following the surgery, he received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker. He also needs help with lower body dressing because of difficulties standing and leaning over.

Coding: Hip Fracture item (I3900), would **not be checked**.

Rationale: Although he has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.

SECTION J: HEALTH CONDITIONS

Intent: The intent of the items in this section is to document a number of health conditions that impact the individual’s functional status and quality of life. The items include an assessment of pain which uses an interview with the individual or caregiver if the individual is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, prognosis, problem conditions, and falls.

J0100: Pain Management (5-Day Look-back)

J0100. Pain Management – Complete for the individual, regardless of current pain level	
At any time in the last 5 days, has the individual:	
Enter <input type="text"/> Code	A. Received scheduled pain medication regimen? 0. No 1. Yes
Enter <input type="text"/> Code	B. Received PRN pain medications OR was offered and declined? 0. No 1. Yes
Enter <input type="text"/> Code	C. Received non-medication intervention for pain? 0. No 1. Yes

Definitions

Pain Medication Regimen – Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.

Scheduled Pain Medication Regimen – A pain medication order that defines dose and specific time interval for pain medication administration, for example, “once a day,” “every 12 hours.”

PRN Pain Medications – Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as “every 4 hours as needed for pain” or “every 6 hours as needed for pain.”

Non-Medication Pain Intervention – Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal medications are not included in this category.

Item Rationale

Health-related Quality of Life

- Pain can cause suffering and is associated with inactivity, social withdrawal, depression, and functional decline.
- Pain can interfere with participation in rehabilitation.

- Effective pain management interventions can help to avoid these adverse outcomes.

Planning for Care

- Goals for pain management for most individuals should be to achieve a consistent level of comfort while maintaining as much function as possible.
- Identification of pain management interventions, review of the effectiveness of pain management, and revision of the plan if goals are not met.
- Individuals may have more than one source of pain and need a comprehensive, individualized management regimen.
- Most individuals with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as-needed) pain medications for breakthrough pain.
- Some individuals with intermittent or mild pain may have orders for PRN dosing only.
- Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens.
- Interventions must be included as part of a plan of care that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of the plan of care if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.

Step for Assessment

- Review the medical record, if available, to determine what, if any, pain management interventions the individual received during the 5-day look-back period. Include information from all disciplines. If the medical record is not available, ask the individual or caregiver.

Coding Instructions for J0100A-C

Determine all interventions for pain provided to the individual during the 5-day look-back period. Answer these items even if the individual currently denies pain.

Coding Instructions for J0100A, Received Scheduled Pain Medication Regimen

- **Code 0, no:** if the medical record does not contain documentation or the individual/caregiver reports that no scheduled pain medication was received.
- **Code 1, yes:** if the medical record contains documentation or the individual/caregiver reports that a scheduled pain medication was received.

Coding Instructions for J0100B, Received PRN Pain Medication

- **Code 0, no:** if the medical record does not contain documentation or the individual/caregiver reports that no PRN pain medication was received.
- **Code 1, yes:** if the medical record contains documentation or the individual/caregiver reports that a PRN pain medication was either received OR was offered but declined.

Coding Instructions for J0100C, Received Non-medication Intervention for Pain

- **Code 0, no:** if the medical record does not contain documentation or the individual/caregiver reports that no non-medication pain intervention was received.
- **Code 1, yes:** if the medical record contains documentation or the individual/caregiver reports that a non-medication pain intervention was scheduled as part of the plan of care and it is documented that the intervention was actually received and assessed for efficacy.

Coding Tips

- Code only pain medication regimens without PRN pain medications in J0100A. Code receipt of PRN pain medications in J0100B.
- For coding J0100B code only individuals with PRN pain medication regimens here. If the individual has a scheduled pain medication, it should be coded in J0100A.

Examples

1. Mrs. P's caregiver states that she received the following pain management in the past 5 days:
 - Hydrocodone/acetaminophen 5/500 1 tab PO every 6 hours. Discontinued on day 1 of look-back period.
 - Acetaminophen 500mg PO every 4 hours. Started on day 2 of look-back period.
 - Cold pack to left shoulder applied by PT BID. PT notes that individual reports significant pain improvement after cold pack applied.

Coding: J0100A would be **coded 1, yes**.

Rationale: The caregiver stated that she received a scheduled pain medication during the 5-day look-back period.

Coding: J0100B would be **coded 0, no**.

Rationale: The caregiver reported that she declined PRN medications during the 5-day look-back period.

Coding: J0100C would be **coded 1, yes**.

Rationale: The caregiver stated that she received scheduled non-medication pain intervention (cold pack to the left shoulder) during the 5-day look-back period.

2. Mr. L's medical record includes the following pain management documentation:
 - MS-Contin (morphine sulfate controlled-release) 15 mg PO Q 12 hours: Individual refused every dose of medication during the 5-day look-back period. No other pain management interventions were documented.

Coding: J0100A would be **coded 0, no**.

Rationale: The medical record documented that Mr. L did not receive scheduled pain medication during the 5-day look-back period. Individuals may refuse scheduled medications; however, medications are not considered "received" if the individual refuses the dose.

Coding: J0100B would be coded **0, no**.

Rationale: The medical record contained no documentation that Mr. L received or was offered and declined any PRN medications during the 5-day look-back period.

Coding: J0100C would be coded **0, no**.

Rationale: The medical record contains no documentation that Mr. L received non-medication pain intervention during the 5-day look-back period.

J0200: Should Pain Assessment Interview Be Conducted?

J0200. Should Pain Assessment Interview be Conducted? – Attempt to conduct interview with the individual. If individual is comatose, skip to J1100, Shortness of Breath (dyspnea)	
Enter <input type="checkbox"/> Code	0. No (individual is rarely/never understood OR individual is less than 3 years of age) → Skip to J0800, Indicators of Pain or Possible Pain 1. Yes → Continue to J0300, Pain Presence

Item Rationale

Health-related Quality of Life

- Most individuals who are capable of communicating can answer questions about how they feel.
- Obtaining information about pain directly from the individual, sometimes called “hearing the individual’s voice,” is more reliable and accurate than observation alone for identifying pain.
- If an individual cannot communicate (e.g., verbal, gesture, written), then caregiver observations for pain behavior (J0800 and J0850) will be used.

Planning for Care

- Interview allows the individual’s voice to be reflected in the plan of care.
- Information about pain that comes directly from the individual provides symptom-specific information for the plan of care.

Steps for Assessment

1. Determine whether the individual is understood at least sometimes. Review Language item (A1100), to determine whether the individual needs or wants an interpreter.
2. If an interpreter is needed or requested, every effort should be made to have an interpreter present for the interview.

Coding Instructions

Attempt to complete the interview if the individual is at least sometimes understood) and an interpreter is present or not required.

- **Code 0, no:** if the individual is rarely/never understood or an interpreter is required but not available. Skip to **Indicators of Pain or Possible Pain** item (J0800).
- **Code 1, yes:** if the individual is at least sometimes understood and an interpreter is present or not required. Continue to **Pain Presence** item (J0300).

Coding Tips and Special Populations

- If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete **Caregiver Assessment of Pain** item (J0800), instead of the **Pain Interview** items (J0300-J0600).

Pediatric Tip:

If the individual is less than 3 years old code “0” and skip to J0800, “Indicators of Pain or Possible Pain.”

J0300-J0600: Pain Assessment Interview

Pain Assessment Interview	
J0300. Pain Presence	
Enter <input type="checkbox"/> Code	Ask individual: <i>“Have you had pain or hurting at any time in the last 5 days?”</i> 0. No → Skip to J1100, Shortness of Breath 1. Yes → Continue to J0400, Pain Frequency 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain
J0400. Pain Frequency	
Enter <input type="checkbox"/> Code	Ask individual: <i>“How much of the time have you experienced pain or hurting over the last 5 days?”</i> 1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer
J0500. Pain Effect on Function	
Enter <input type="checkbox"/> Code	A. Ask individual: <i>“Over the past 5 days, has pain made it hard for you to sleep at night?”</i> 0. No 1. Yes 9. Unable to answer
Enter <input type="checkbox"/> Code	B. Ask individual: <i>“Over the past 5 days, have you limited your day-to-day activities because of pain?”</i> 0. No 1. Yes 9. Unable to answer
J0600. Pain Intensity – Administer ONLY ONE of the following pain intensity questions (A or B)	
Enter <input type="text"/> Rating	A. Numeric Rating Scale (00–10) Ask individual: <i>“Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.”</i> (Show individual 00 -10 pain scale) Enter two-digit response. Enter 99 if unable to answer.
Enter <input type="checkbox"/> Code	B. Verbal Descriptor Scale Ask individual: <i>“Please rate the intensity of your worst pain over the last 5 days.”</i> (Show individual verbal scale) 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer

Definitions

Pain - Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does.

Nonsensical response – Any unrelated, incomprehensible, or incoherent response that is not informative with respect to the item being coded.

Item Rationale

Health-related Quality of Life

- The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired individuals.
- Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.

Planning for Care

- Directly asking the individual about pain rather than relying on the individual to volunteer the information or relying on observation significantly improves the detection of pain.
- Individual self-report is the most reliable means for assessing pain.
- Pain assessment provides a basis for evaluation treatment need and response to treatment.
- Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential implications for planning of care.
- Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities.
- Pain assessment prompts discussion about factors that aggravate and alleviate pain.
- Similar pain stimuli can have varying impact on different individuals.
- Consistent use of a standardized pain intensity scale improves the validity and reliability of pain assessment. Using the same scale in different settings may improve continuity of care.
- Pain intensity scales allow providers to evaluate whether an individual is responding to pain medication regime(s) and/or non-pharmacological intervention(s).

Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600)

1. Interview any individual not screened out by the **Should Pain Assessment Interview be Conducted?** item (J0200).

2. The Pain Assessment Interview for individuals consists of four items: the primary question **Pain Presence** item (J0300), and three follow-up questions **Pain Frequency** item (J0400); **Pain Effect on Function** item (J0500); and **Pain Intensity** item (J0600). If the individual is unable to answer the primary question on pain presence J0300, skip to the **Caregiver Assessment for Pain** beginning with **Indicators of Pain or Possible Pain** item (J0800).
3. The look-back period on these items is 5 days. Because this item asks the individual to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5-day look-back period; preferably on the day before, or the assessment date. This should more accurately capture pain episodes that occur during the 5-day look-back period.
4. Conduct the interview in a private setting.
5. Be sure the individual can hear you.
 - Individuals with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
 - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
 - Minimize background noise.
6. Sit so that the individual can see your face. Minimize glare by directing light sources away from the individual’s face.
7. Give an introduction before starting the interview.
 - Suggested language: “I’d like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain.”
8. Directly ask the individual each item in J0300 through J0600 in the order provided.
 - Use other terms for pain or follow-up discussion if the individual seems unsure or hesitant. Some individuals avoid use of the term “pain” but may report that they “hurt.” Individuals may use other terms such as “aching” or “burning” to describe pain.
9. If the individual chooses not to answer a particular item, accept his or her refusal, **code 9** and move to the next item.
10. If the individual is unsure about whether the pain occurred in the 5-day time interval, prompt the individual to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.

J0300: Pain Presence (5-Day Look-Back)

J0300. Pain Presence	
Enter <input type="text"/> Code	Ask individual: <i>“Have you had pain or hurting at any time in the last 5 days?”</i> 0. No → Skip to J1100, Shortness of Breath 1. Yes → Continue to J0400, Pain Frequency 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain

Step for Assessment

1. Ask the individual: “Have you had pain or hurting at any time in the last 5 days?”

Coding Instructions for J0300, Pain Presence

Code for the presence or absence of pain regardless of pain management efforts during the 5-day look-back period.

- **Code 0, no:** if the individual responds “no” to any pain in the 5-day look-back period. **Code 0, no pain**, even if the reason for no pain is that the individual received pain management interventions. If coded 0, the pain interview is complete. Skip to **Shortness of Breath** item (J1100).
- **Code 1, yes:** if the individual responds “yes” to pain at any time during the look-back period. If coded 1, proceed to **Pain Frequency** item (J0400).
- **Code 9, unable to answer:** if the individual is unable to answer, does not respond, or gives a nonsensical response. If coded 9, skip to the Caregiver Assessment for Pain beginning with **Indicators of Pain or Possible Pain** item (J0800).

Coding Tips

- Rates of self-reported pain are higher than observed rates. Although some observers have expressed concern that individuals may not complain and may deny pain, the regular and objective use of self-report pain scales enhances individuals’ willingness to report.

Examples

1. When asked about pain, Mrs. S. responds, “No. I have been taking the pain medication regularly, so fortunately I have had no pain.”

Coding: J0300 would be **coded 0, no**. The assessor would skip to **Shortness of Breath** item (J1100).

Rationale: Mrs. S. reports having no pain during the look-back period. Even though she received pain management interventions during the look-back period, the item is coded “No,” because there was no pain.

2. When asked about pain, Mr. T. responds, “No pain, but I have had a terrible burning sensation all down my leg.”

Coding: J0300 would be **coded 1, yes**. The assessor would proceed to **Pain Frequency** item (J0400).

Rationale: Although Mr. T.’s initial response is “no,” the comments indicate that he has experienced pain (burning sensation) during the look-back period.

3. When asked about pain, Ms. G. responds, “I was on a train in 1905.”

Coding: J0300 would be **coded 9, unable to respond**. The assessor would skip to **Indicators of Pain** item (J0800).

Rationale: Ms. G. has provided a nonsensical answer to the question. The assessor will complete the **Caregiver Assessment for Pain** beginning with **Indicators of Pain** item (J0800).

J0400: Pain Frequency (5-Day Look-Back)

J0400. Pain Frequency	
Enter <input type="text"/> Code	Ask individual: "How much of the time have you experienced pain or hurting over the last 5 days?" 1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer

Steps for Assessment

1. Ask the individual: "How much of the time have you experienced pain or hurting over the last 5 days?" The nurse assessor may present response options on a written sheet or cue card. This can help the individual respond to the items.
2. If the individual provides a related response but does not use the provided response scale, help clarify the best response by echoing (repeating) the individual's own comment and providing related response options. This interview approach frequently helps the individual clarify which response option he or she prefers.
3. If the individual, despite clarifying statements and repeating response options, continues to have difficulty selecting between two of the provided responses, then select the more frequent of the two.

Coding Instructions

Code for pain frequency during the 5-day look-back period.

- **Code 1, almost constantly:** if the individual responds "almost constantly" to the question.
- **Code 2, frequently:** if the individual responds "frequently" to the question.
- **Code 3, occasionally:** if the individual responds "occasionally" to the question.
- **Code 4, rarely:** if the individual responds "rarely" to the question.
- **Code 9, unable to answer:** if the individual is unable to respond, does not respond, or gives a nonsensical response. Proceed to items J0500, J0600, and J0700.

Coding Tips

- No predetermined definitions are offered to the individual related to frequency of pain.
 - The response should be based on the individual's interpretation of the frequency options.

Examples

1. When asked about pain, Mrs. C. responds, "All the time. It has been a terrible week. I have not been able to get comfortable for more than 10 minutes at a time since I started physical therapy four days ago."

Coding: J0400 would be coded **1, almost constantly**.

Rationale: Mrs. C. describes pain that has occurred "all the time."

- When asked about pain, Mr. J. responds, “I don’t know if it is frequent or occasional. My knee starts throbbing every time they move me from the bed or the wheelchair.” The interviewer says: “Your knee throbs every time they move you. If you had to choose an answer, would you say that you have pain frequently or occasionally?” Mr. J. is still unable to choose between frequently and occasionally.

Coding: J0400 would be **coded 2, frequently**.

Rationale: The interviewer appropriately echoed Mr. J.’s comment and provided related response options to help him clarify which response he preferred. Mr. J. remained unable to decide between frequently and occasionally. The interviewer therefore coded for the higher frequency of pain.

- When asked about pain, Miss K. responds: “I can’t remember. I think I had a headache a few times in the past couple of days, but they gave me acetaminophen and the headaches went away.” The interviewer clarifies by echoing what Miss K. said: “You’ve had a headache a few times in the past couple of days and the headaches went away when you were given acetaminophen. If you had to choose from the answers, would you say you had pain occasionally or rarely?” Miss K. replies “Occasionally.”

Coding: J0400 would be **coded 3, occasionally**.

Rationale: After the interviewer clarified the individual’s choice using echoing, the individual selected a response option.

- When asked about pain, Ms. M. responds, “I would say rarely. Since I started using the patch, I don’t have much pain at all, but four days ago the pain came back. I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day.”

Coding: J0400 would be **coded 4, rarely**.

Rationale: Ms. M. selected the “rarely” response option.

J0500: Pain Effect on Function (5-Day Look-Back)

J0500. Pain Effect on Function	
Enter <input type="checkbox"/> Code	A. Ask individual: “Over the past 5 days, has pain made it hard for you to sleep at night?” 0. No 1. Yes 9. Unable to answer
Enter <input type="checkbox"/> Code	B. Ask individual: “Over the past 5 days, have you limited your day-to-day activities because of pain?” 0. No 1. Yes 9. Unable to answer

Steps for Assessment

- Ask the individual each of the two questions exactly as they are written.
- If the individual’s response does not lead to a clear “yes” or “no” answer, repeat the individual’s response and then try to narrow the focus of the response. For example, if the individual responded to the question, “Has pain made it hard for you to sleep at night?” by saying, “I always have trouble sleeping,” then the assessor might reply, “You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?”

Coding Instructions for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?

- **Code 0, no:** if the individual responds “no,” indicating that pain did not interfere with sleep.
- **Code 1, yes:** if the individual responds “yes,” indicating that pain interfered with sleep.
- **Code 9, unable to answer:** if the individual is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0500B, J0600 and J0700.

Coding Instructions for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?”

- **Code 0, no:** if the individual indicates that pain did not interfere with daily activities.
- **Code 1, yes:** if the individual indicates that pain interfered with daily activities.
- **Code 9, unable to answer:** if the individual is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0600 and J0700.

Pediatric Tips:

J0500A: Ask the child: “Do you wake up at night because you hurt?”

J0500B: Ask the child: “Are there things you would like to do or games you would like to play but can’t because they make you hurt?”

Examples for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?

1. Mrs. D responds, “I had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. I slept like a baby.”

Coding: J0500A would be **coded 0, no.**

Rationale: Mrs. D reports no sleep problems related to pain.

2. Mr. E responds, “I can’t sleep at all in this place.” The interviewer clarifies by saying, “You can’t sleep here. Would you say that was because pain made it hard for you to sleep at night?” Mr. E. responds, “No. It has nothing to do with me. I have no pain. It is because everyone is making so much noise.”

Coding: J0500A would be **coded 0, no.**

Rationale: Mr. E reports that his sleep problems are not related to pain.

3. Miss G responds, “Yes, the back pain makes it hard to sleep. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much.”

Coding: J0500A would be **coded 1, yes.**

Rationale: Miss G reports pain-related sleep problems.

Examples for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?"

- Ms. L responds, "No, I had some pain on Wednesday, but I didn't want to miss the shopping trip, so I went."

Coding: J0500B would be **coded 0, no.**

Rationale: Although Ms. L reports pain, she did not limit her activity because of it.

- Mrs. N responds, "Yes, I haven't been able to play the piano, because my shoulder hurts."

Coding: J0500B would be **coded 1, yes.**

Rationale: Mrs. N reports limiting her activities because of pain.

- Mrs. S responds, "I don't know. I have not tried to knit since my finger swelled up yesterday, because I am afraid it might hurt even more than it does now."

Coding: J0500B would be **coded 1, yes.**

Rationale: Mrs. S avoided a usual activity because of fear that her pain would increase.

- Mr. Q responds, "I don't like painful activities." Interviewer repeats question and Mr. Q. responds, "I designed a plane one time."

Coding: J0500B would be **coded 9, unable to answer.**

Rationale: Mr. Q has provided a nonsensical answer to the question. Proceed to items J0600 and J0700.

J0600: Pain Intensity (5-Day Look-Back)

J0600. Pain Intensity – Administer ONLY ONE of the following pain intensity questions (A or B)	
Enter <input type="text"/> Rating	<p>A. Numeric Rating Scale (00–10) Ask individual: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show individual 00-10 pain scale) Enter two-digit response. Enter 99 if unable to answer.</p>
Enter <input type="text"/> Code	<p>B. Verbal Descriptor Scale Ask individual: "Please rate the intensity of your worst pain over the last 5 days." (Show individual verbal scale)</p> <ol style="list-style-type: none"> 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer

Steps for Assessment

- You may use either **Numeric Rating Scale** item (J0600A) or **Verbal Descriptor Scale** item (J0600B) to interview the individual about pain intensity.
 - For each individual, try to use the same scale used on prior assessments.
- If the individual is unable to answer using one scale, the other scale should be attempted.

- Record either the Numeric Rating Scale item (J0600A) or the Verbal Descriptor Scale item (J0600B). Leave the response for the unused scale blank.
- Read the question and item choices slowly. While reading, you may show the individual the response options (the Numeric Rating Scale or Verbal Descriptor Scale) clearly printed on a piece of paper, such as a cue card. Use large, clear print.
 - For Numeric Rating Scale, say, “Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine.”
 - For Verbal Descriptor Scale, say, “Please rate the intensity of your worst pain over the last 5 days.”
- The individual may provide a verbal response, point to the written response, or both.

Coding Instructions for J0600A. Numeric Rating Scale (00-10)

Enter the two digit number (00-10) indicated by the individual as corresponding to the intensity of his or her worst pain during the 5-day look-back period, where zero is no pain, and 10 is the worst pain imaginable.

- Enter 99 if unable to answer.
- If the Numeric Rating Scale is not used, leave the response box blank.

Coding Instructions for J0600B. Verbal Descriptor Scale

- **Code 1, mild:** if individual indicates that his or her pain is “mild.”
- **Code 2, moderate:** if individual indicates that his or her pain is “moderate.”
- **Code 3, severe:** if individual indicates that his or her pain is “severe.”
- **Code 4, very severe, horrible:** if individual indicates that his or her pain is “very severe or horrible.”
- **Code 9, unable to answer:** if individual is unable to answer, chooses not to respond, does not respond or gives a nonsensical response. Proceed to item J0700.
- If the **Verbal Descriptor Scale** is not used, leave the response box blank.

Examples for J0600A. Numeric Rating Scale (00-10)

1. The nurse asks Ms. T. to rate her pain on a scale of 0 to 10. Ms. T. states that she is not sure, because she has shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK. The nurse reminds Ms. T. to think about all the pain she had during the last 5 days and select the number that describes her worst pain. She reports that her pain is a “6.”

Coding: J0600A would be **coded 06**.

Rationale: Ms. T said her pain was 6 on the 0 to 10 scale. Because a 2-digit number is required, it is entered as 06.

- The nurse asks Mr. S. to rate his pain, reviews use of the scale, and provides the 0 to 10 visual aid. Mr. S. says, “My pain doesn’t have any numbers.” The nurse explains that the numbers help his caregivers understand how severe his pain is, and repeats that the “0” end is no pain and the “10” end is the worst pain imaginable. Mr. S. replies, “I don’t know where it would fall.”

Coding: Item J0600A would be **coded 99, unable to answer**. The interviewer would go on to ask about pain intensity using the **Verbal Descriptor Scale** item (J0600B).

Rationale: Mrs. S was unable to select a number or point to a location on the 0-10 scale that represented his level of pain intensity.

Examples for J0600B. Verbal Descriptor Scale

- The nurse asks Mr. R. to rate his pain using the verbal descriptor scale. He looks at the response options presented using a cue card and says his pain is “severe” sometimes, but most of the time it is “mild.”

Coding: J0600B would be **coded 3, severe**.

Rationale: Mr. R said his worst pain was “Severe.”

- The nurse asks Ms. U. to rate her pain, reviews use of the verbal descriptor scale, and provides a cue card as a visual aid. Ms. U. says, “I’m not sure whether it’s mild or moderate.” The nurse reminds Ms. U. to think about her worst pain during the last 5 days. Ms. U. says “At its worst, it was moderate.”

Coding: Item J0600B would be **coded 2, moderate**.

Rationale: Ms. U indicated that her worst pain was “Moderate.”

J0700: Should the Caregiver Assessment for Pain be Conducted? (5-Day Look-Back)

Item J0700 closes the pain interview and determine if the individual interview was complete or incomplete and based on this determination, whether a caregiver assessment needs to be completed.

J0700. Should the Caregiver Assessment for Pain be Conducted?	
Enter Code	<ol style="list-style-type: none"> No (J0400=1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea) Yes (J0400=9) → Continue to J0800, Indicators of Pain or Possible Pain

Definition

Completed Interview – The pain interview is successfully completed if the individual reported no pain (answered no to J0300), or if the individual reported pain (J0300=yes) and the follow-up question J0400 is answered.

Item Rationale

Health-related Quality of Life

- Individual interview for pain is preferred because it improves the detection of pain. However, a small percentage of individuals are unable or unwilling to complete the pain interview.
- Persons unable to complete the pain interview may still have pain.

Planning for Care

- Individual self-report is the most reliable means of assessing pain. However, when an individual is unable to provide the information, caregiver assessment is necessary.
- Even though the individual was unable to complete the interview, important insights may be gained from the responses that were obtained, observing behaviors and observing the individual's affect during the interview.

Step for Assessment

1. Review the individual's responses to J0200 – J0400.
2. The **Caregiver Assessment for Pain** should only be completed if the **Pain Assessment Interview** (J0200-J0600) was not completed.

Coding Instructions for J0700. Should the Caregiver Assessment for Pain be Conducted? This item is to be coded at the completion of items J0400-J0600.

- **Code 0, no:** if the individual completed the **Pain Assessment Interview** item (J0400 = 1, 2, 3, or 4. Skip to **Shortness of Breath (dyspnea)** item (J1100).
- **Code 1, yes:** if the individual was unable to complete the **Pain Assessment Interview** (J0400 = 9). Continue to **Indicators of Pain or Possible Pain** item (J0800).

Pediatric Tip:

Complete the Caregivers Assessment for Pain if the child is less than 3 years old or if the nurse assessor determines that the child is unable to answer the questions in J0300 – J0600.

J0800: Indicators of Pain (5-Day Look-Back)

Complete this item only if the *Pain Assessment Interview* (J0200-J0600) was not completed.

Caregiver Assessment for Pain	
J0800. Indicators of Pain or Possible Pain in the last 5 days	
↓ Check all that apply	
<input type="checkbox"/>	A. Non-verbal sounds (crying, whining, gasping, moaning, or groaning)
<input type="checkbox"/>	B. Vocal complaints of pain (that hurts, ouch, stop)
<input type="checkbox"/>	C. Facial expressions (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
<input type="checkbox"/>	D. Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
<input type="checkbox"/>	Z. None of these signs observed or documented → If checked, skip to J1100, Shortness of Breath (dyspnea)

Definitions

Non-verbal sounds – Crying, whining, gasping, moaning, groaning or other audible indications associated with pain.

Vocal complaints of pain – “That hurts,” “ouch,” “stop,” etc.

Facial expressions that may be indicators of pain - Grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw, etc.

Protective body movement or postures – Bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, etc.

Item Rationale

Health-related Quality of Life

- Individuals who cannot verbally communicate about their pain are at particularly high risk for underdetection and undertreatment of pain.
- Severe cognitive impairment may affect the ability of individuals to verbally communicate, thus limiting the availability of self-reported information about pain. In these cognitively impaired individuals, fewer complaints may not mean less pain.
- Individuals who are unable to verbally communicate may be more likely to use alternative methods of expression to communicate their pain.
- Even in cognitively impaired individuals, some verbal complaints of pain may be made and should be taken seriously.

Planning for Care

- Consistent approach to observation improves the accuracy of pain assessment for individuals who are unable to verbally communicate their pain.
- Particular attention should be paid to using the indicators of pain during activities when pain is most likely to be demonstrated (e.g., bathing, transferring, dressing, walking and potentially during eating).
- Caregivers should carefully monitor, track, and document any possible signs and symptoms of pain.
- Identification of these pain indicators can:

- Provide a basis for more comprehensive pain assessment,
- Provide a basis for determining appropriate treatment, and
- Provide a basis for ongoing monitoring of pain presence and treatment response.
- If pain indicators are present, assessment should identify aggravating/alleviating factors related to pain.

Steps for Assessment

1. **Review the medical record, if available**, for documentation of each indicator of pain listed in J0800 that occurred during the 5-day look-back period. If the record documents the presence of any of the signs and symptoms listed, confirm your record review with caregivers who work most closely with the individual during ADLs.
2. **Interview caregivers.** Because the medical record may not be available or may fail to note all observable pain behaviors, for any indicators that were not noted as present in medical record review, interview the caregiver who works with the individual during bathing, dressing, transferring, and eating activities. Ask directly about the presence of each indicator that was not noted as being present in the record.
3. **Observe the individual** during care activities. If you observe additional indicators of pain during the 5-day look-back period, code the corresponding items.
 - Observations for pain indicators may be more sensitive if the individual is observed during ADL or wound care.

Coding Instructions

Check all that applied in the past 5 days based on caregiver observation of pain indicators.

- If the medical record review, interview with caregiver, and nurse assessor observation provide no evidence of pain indicators, Check J0800Z, None of these **signs observed or documented**, and proceed to **Shortness of Breath** item (J1100).
- **Check J0800A, non-verbal sounds:** included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported during the look-back period.
- **Check J0800B, vocal complaints of pain:** included but not limited to if the individual was observed to make vocal complaints of pain (e.g., “that hurts,” “ouch,” or “stop”).
- **Check J0800C, facial expressions:** included but not limited to if grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw were observed or reported during the look-back period.
- **Check J0800D, protective body movements or postures:** included but not limited to if bracing, guarding, rubbing or massaging a body part/area, or clutching or holding a body part during movement were observed or reported during the look-back period.
- **Check J0800Z, none of these signs observed or documented:** if none of these signs were observed or reported during the look-back period.

Coding Tips

- Behavior change, depressed mood, rejection of care and decreased activity participation may be related to pain. These behaviors and symptoms are identified in other sections and not reported here as pain screening items. However, the contribution of pain should be considered when following up on those symptoms and behaviors.

Examples

1. Mr. P. has advanced dementia and is unable to verbally communicate. A note in his medical record documents that he has been awake during the last night crying and rubbing his elbow. When interviewing the caregiver, you observe Mr. P. grimacing and clenching his teeth. The caregiver reports that he has been moaning and said “ouch” when she tried to move his arm.

Coding: **Non-verbal Sounds** item (J0800A); **Vocal Complaints of Pain** item (J0800B); **Facial Expressions** item (J0800C); and **Protective Body Movements or Postures** item (J0800D), would be **checked**.

Rationale: Mr. P. has demonstrated vocal complaints of pain (ouch), non-verbal sounds (crying and moaning), facial expression of pain (grimacing and clenched teeth), and protective body movements (rubbing his elbow).

2. Mrs. M. has end-stage Parkinson’s disease and is unable to verbally communicate. There is no documentation of pain in her medical record during the 5-day look-back period. The caregivers report that on some mornings she moans and winces when her arms and legs are moved during morning care. During direct observation, you note that Mrs. M. cries and attempts to pull her hand away when the caregiver tries to open the contracted hand to wash it.

Coding: **Non-verbal Sounds** items (J0800A); **Facial Expressions** item (J0800C); and **Protective Body Movements or Postures** item (J0800D), would be **checked**.

Rationale: Mrs. M. has demonstrated non-verbal sounds (crying, moaning); facial expression of pain (wince), and protective body movements (attempt to withdraw).

3. Mrs. E. has been unable to verbally communicate following a massive cerebrovascular accident (CVA) several months ago and has a Stage 3 pressure ulcer/injury. There is no documentation of pain in her medical record. The caregiver reports that she does not seem to have any pain. You observe the individual during her pressure ulcer/injury dressing change. During the treatment, you observe groaning, facial grimaces, and a wrinkled forehead.

Coding: **Non-verbal Sounds** item (J0800A), and **Facial Expressions** item (J0800C), would be **checked**.

Rationale: Mrs. E has demonstrated non-verbal sounds (groaning) and facial expression of pain (wrinkled forehead and grimacing).

4. Mr. S. is in a persistent vegetative state following a traumatic brain injury. He is unable to verbally communicate. There is no documentation of pain in his medical record during the 5-day look-back period. The caregiver reports that he appears comfortable whenever she cares for him. You observe the caregiver providing morning care and transferring him from bed to

chair. No pain indicators are observed at any time.

Coding: None of These Signs Observed or Documented item (J0800Z) would be checked.

Rationale: All steps for the assessment have been followed and no pain indicators have been documented, reported or directly observed.

J0850: Frequency of Indicator of Pain or Possible Pain (5-Day Look-Back)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days	
Enter Code	Frequency with which individual complains or shows evidence of pain or possible pain
<input type="checkbox"/>	1. Indicators of pain or possible pain observed 1 to 2 days
	2. Indicators of pain or possible pain observed 3 to 4 days
	3. Indicators of pain or possible pain observed daily

Item Rationale

Health-related Quality of Life

- Unrelieved pain adversely affects function and mobility contributing to dependence, skin breakdown, contractures, and weight loss.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as to an increase in behavior problems, particularly for cognitively impaired individuals.

Planning for Care

- Assessment of pain frequency provides:
 - A basis for evaluating treatment need and response to treatment.
 - Information to aide in identifying optimum timing of treatment.

Step for Assessment

1. Interview caregivers to determine the number of days the individual either complained of pain or showed evidence of pain as described in J0800 over the past 5 days.

Coding Instructions

Code for pain frequency over the last 5 days.

- **Code 1:** if based on caregiver observation, the individual complained or showed evidence of pain 1 to 2 days.
- **Code 2:** if based on caregiver observation, the individual complained or showed evidence of pain on 3 to 4 of the last 5 days.
- **Code 3:** if based on caregiver observation, the individual complained or showed evidence of pain on a daily basis.

Examples

1. Mr. M. is an 80-year old male with advanced dementia. During the 5-day look-back period, Mr. M. was noted to be grimacing and verbalizing “ouch” over the past 2 days when his right shoulder was moved.

Coding: Item J0850 would be **coded 1, indicators of pain observed 1 to 2 days.**

Rationale: He has demonstrated vocal complaints of pain (“ouch”), facial expression of pain (grimacing) on 2 of the last 5 days.

2. Mrs. C. is a 78-year old female with a history of CVA with expressive aphasia and dementia. During the 5-day look-back period, the individual was noted on a daily basis to be rubbing her right knee and grimacing.

Coding: Item J0850 would be **coded 3, indicators of pain observed daily.**

Rationale: Mrs. C was observed with a facial expression of pain (grimacing) and protective body movements (rubbing her knee) every day during the look-back period.

J1100 Shortness of Breath (dyspnea)

Other Health Conditions	
J1100. Shortness of Breath (dyspnea)	
↓ Check all that apply	
<input type="checkbox"/>	A. Shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring)
<input type="checkbox"/>	B. Shortness of breath or trouble breathing when sitting at rest
<input type="checkbox"/>	C. Shortness of breath or trouble breathing when lying flat
<input type="checkbox"/>	Z. None of the above

Item Rationale

Health-related Quality of Life

- Shortness of breath can be an extremely distressing symptom and lead to decreased interaction and quality of life.
- Some individuals compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath while lying flat by elevating the head of the bed and do not alert caregivers to the problem.

Planning for Care

- Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.
- The plan of care should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

Steps for Assessment

Interview the individual about shortness of breath. Many individuals, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.

1. If the individual is not experiencing shortness of breath or trouble breathing during the interview, ask the individual if shortness of breath occurs when he or she engages in certain activities.
2. Review the medical record, if available, for documentation of the presence of shortness of breath or trouble breathing. Interview the caregiver regarding individual history of shortness of breath, allergies or other environmental triggers of shortness of breath.
3. Observe the individual for shortness of breath or trouble breathing. Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe.
4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

Coding Instructions

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

Any evidence of the presence of a symptom of shortness of breath should be captured in this item.

An individual may have any combination of these symptoms.

- **Check J1100A:** if shortness of breath or trouble breathing is present when the individual is engaging in activity. Shortness of breath could be present during activity as limited as turning or moving in bed during daily care or with more strenuous activity such as transferring, walking, or bathing. If the individual avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.
- **Check J1100B:** if shortness of breath or trouble breathing is present when the individual is sitting at rest.
- **Check J1100C:** if shortness of breath or trouble breathing is present when the individual attempts to lie flat. Also code this as present if the individual avoids lying flat because of shortness of breath.
- **Check J1100Z:** if the individual reports no shortness of breath or trouble breathing and the medical record and/or caregiver interviews indicate that shortness of breath appears to be absent or well controlled with current medication.

Examples

1. Mrs. W. has a diagnosis of chronic obstructive pulmonary disease (COPD) and heart failure. She is on 2 liters of oxygen and daily respiratory treatments. With oxygen she is able to ambulate and participate in most activities. She reports feeling “winded” when walking one or more blocks and has been observed having to stop to rest several times under such circumstances. Recently, she describes feeling “out of breath” when she tries to lie down.

Coding: J1100A and J1100C would be **checked**.

Rationale: Mrs. W. reported being short of breath when lying down as well as during outings that required ambulating longer distances.

2. Mr. T. has used an inhaler for years. He is not typically noted to be short of breath. Three days ago, during a respiratory illness, he had mild trouble with his breathing, even when sitting in bed. His shortness of breath also caused him to limit activities.

Coding: J1100A and J1100B would be **checked**.

Rationale: Mr. T. was short of breath at rest and was noted to avoid activities because of shortness of breath.

J1400: Prognosis

J1400. Prognosis	
Enter Code	Does the individual have a condition or chronic disease that may result in a life expectancy of less than 6 months?
<input type="checkbox"/>	0. No
	1. Yes

Definitions

Condition or Chronic Disease – In the physician’s judgment, the individual has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average individual with that level of illness would not be expected to survive more than 6 months. This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single individual. Physician judgment should be based on typical or average life expectancy of individuals with similar level of disease burden as this.

Hospice services – A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if an individual is on hospice the expectation is that the documentation is in the medical record.

Terminally Ill - “terminally ill” means the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

Item Rationale

Health-related Quality of Life

- Individuals with conditions or diseases that may result in a life expectancy of less than 6 months have special needs and may benefit from palliative or hospice services.

Planning for Care

- If life expectancy is less than 6 months, an interdisciplinary team plan of care should be based on the individual's preferences for goals and interventions of care whenever possible.

Steps for Assessment

1. Review the medical record, if available, for documentation by the physician that the individual's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness.
2. If a medical record is not available, ask the individual or caregiver if the individual has a condition or chronic disease that may result in a life expectancy of less than 6 months or a terminal illness.
3. If the answer to #2 is yes, the nurse assessor must verify prognosis with the individual's physician (Do not code 1, yes, unless there is documentation available).

Coding Instructions

- **Code 0, no:** if there is no documentation indicating that the individual is terminally ill and the individual is not receiving hospice services.
- **Code 1, yes:** if the medical record includes physician documentation: 1) that the individual is terminally ill; or 2) the individual is receiving hospice services.

Pediatric Tip:

This question should be asked of the parent/caregiver.

Examples

1. Mrs. T. has a diagnosis of heart failure. During the past few months, she has had three hospital admissions for acute heart failure. Her heart has become significantly weaker despite maximum treatment with medications and oxygen. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival beyond the next couple of months is poor.

Coding: J1400 would be **coded 1, yes**.

Rationale: The physician documented that her life expectancy is likely to be less than 6 months.

- Mr. J. was diagnosed with non-small cell lung cancer and is not a candidate for surgical or curative treatment. With his consent, Mr. J. has been referred to hospice by his physician, who documented that his life expectancy was less than 6 months.

Coding: J1400 would be **coded**

Rationale: The physician referred the individual’s expectancy is likely to be less than 6 months.

J1550: Problem Conditions

J1550. Problem Conditions	
↓ Check all that apply:	
<input type="checkbox"/>	A. Fever
<input type="checkbox"/>	B. Vomiting
<input type="checkbox"/>	C. Dehydrated
<input type="checkbox"/>	D. Internal bleeding
<input type="checkbox"/>	E99. Syncope
<input type="checkbox"/>	Z. None of the above

Definitions

Fever – is defined as a temperature **2.4 degrees F higher than baseline.**

Vomiting – Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).

Internal Bleeding – Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting “coffee grounds”, hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded in internal bleeding.

Item rationale

Health-related Quality of Life

- Timely assessment is needed to identify underlying causes and risk for complications.

Planning for Care

- Implementation of plans of care to treat underlying causes and avoid complications is critical.

Steps for Assessment

- Review the medical record, if available, interview caregivers, and observe the individual for any indication that the individual had vomiting, fever, potential indicators of dehydration, or internal bleeding during the 7-day look-back period.

Coding Instructions

- **J1550A**, fever ®
- **J1550B**, vomiting ®
- **J1550C**, **dehydrated**®
- **J1550D**, internal bleeding ®
- **J1550E99**, syncope
- **J1550Z**, none of the above

Coding Tips

Dehydrated: Check this item if the individual has two or more of the following indicators:

- Individual or caregiver reports that the individual usually takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
- Individual or caregiver reports that the individual's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
- The nurse assessor identifies that the individual has one or more potential clinical signs (indicators) of dehydration, including, but not limited to: dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).

Pediatric Tip:

This question should be asked of the parent/caregiver.

J1700: Fall History

J1700. Fall History	
Complete only if A0310A = 01	
Enter <input type="checkbox"/> Code	A. Did the individual have a fall any time in the last month ? 0. No 1. Yes 9. Unable to determine
Enter <input type="checkbox"/> Code	B. Did the individual have a fall any time in the last 2–6 months ? 0. No 1. Yes 9. Unable to determine
Enter <input type="checkbox"/> Code	C. Did the individual have any fracture related to a fall in the last 6 months ? 0. No 1. Yes 9. Unable to determine

Definitions

Fall – Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the individual, caregiver, or identified when an individual is found on the floor or ground. Falls include any fall, no matter where it occurred. Falls are not a result of an overwhelming external force (e.g., an individual pushes another individual.) An intercepted fall occurs when the individual would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

Fracture Related to a Fall – Any documented bone fracture (in a problem list from a medical record, an X-ray report, or by history of the individual or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the individual.

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of injury, morbidity, and mortality in older adults.
- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.

Planning for Care

- Determine the potential need for further assessment and intervention, including evaluation of the individual's need for rehabilitation or assistive devices.
- Evaluate the physical environment as well as caregiving needs for individuals who are at risk for falls.

Steps for Assessment

Complete only if A0310 type of assessment is 01 Initial Assessment. The period of review is 180 days (6 months) prior to Initial Assessment, looking back from the individual's assessment date (A2300).

1. Ask the individual or caregiver about a history of falls in the month prior to the Initial Assessment and in the 6 months prior to the Initial Assessment. This would include any fall, no matter where it occurred.
2. Review transfer information (if the individual is being transferred from another setting) for evidence of falls.
3. If available, review all relevant medical records received from other settings where the individual may have resided during the previous 6 months; also review any other medical records received for evidence of one or more falls.

**Coding Instructions for J1700A, Did the Individual Have a Fall Any Time in the Last Month?
(30-Day Look-back)**

- **Code 0, no:** if individual or caregivers report no falls or records do not document a fall in the last month (A2300).
- **Code 1, yes:** if individual or caregivers report falls or records document a fall in the last month (A2300).
- **Code 9, unable to determine:** if the individual or caregiver is unable to provide the information or records are unavailable or inadequate to determine whether a fall occurred.

**Coding Instructions for J1700B, Did the Individual Have a Fall Any Time in the Last 2-6 Months?
(60-180 Day Look-back)**

- **Code 0, no:** if individual or caregivers report no falls or records do not document a fall in the last 2-6 months (A2300).
- **Code 1, yes:** if individual or caregivers report falls or records document a fall in the last 2-6 months (A2300).
- **Code 9, unable to determine:** if the individual or caregiver is unable to provide the information, or records are unavailable or inadequate to determine whether a fall occurred.

**Coding Instructions for J1700C. Did the Individual Have Any Fracture Related to a Fall in the Last 6 Months?
(180-Day Look-back)**

- **Code 0, no:** if individual or caregivers report no fractures related to falls or records do not document a fracture related to fall in the last 6 months (0-180 days) (A2300).
- **Code 1, yes:** if individual or caregivers report or records document a fracture related to fall in the last 6 months (0-180 days) (A2300).
- **Code 9, unable to determine:** if the individual or caregivers is unable to provide the information, or records are unavailable or inadequate to determine whether a fracture occurred related to a fall in the last 6 months.

Pediatric Tip:

J1700A and J1700B: Code reported falls even in situations when the falls are expected, for example, a toddler learning to walk or a child with cerebral palsy.

Examples

1. On assessment interview, Mrs. J. is asked about falls and says she has "not really fallen." However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.

Coding: J1700A would be **coded 1, yes**.

Rationale: Falls caused by slipping meet the definition of falls.

2. On assessment interview, an individual denies a history of falling. However, her daughter says that she found her mother on the floor near her toilet twice about 3-4 months ago.

Coding: J1700B would be **coded 1, yes**.

Rationale: If the individual is found on the floor, a fall is assumed to have occurred.

3. On assessment interview, Mr. M. and his caregivers deny any history of falling. However, nursing notes in a hospital record document that Mr. M. repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at his bedside to prevent injury the week prior to community setting transfer.

Coding: J1700A would be **coded 1, yes**.

Rationale: Medical records from an outside setting document that Mr. M. was found on a mat on the floor. This is defined as a fall.

4. Medical records note that Miss K. had hip surgery 5 months prior to Initial Assessment in a community setting. Miss K.'s daughter says the surgery was needed to fix a broken hip due to a fall.

Coding: Both J1700B and J1700C would be **coded 1, yes**.

Rationale: Miss K. had a fall related fracture 1-6 months prior to community setting entry.

5. Mr. O. has a hospital record that includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Mr. O. denies any history of falling.

Coding: J1700C would be **coded 0, no**.

Rationale: The fractures were not related to a fall.

6. Ms. P. has a history of a "Colle's fracture" of her left wrist about 3 weeks before Initial Assessment upon entry into a community setting. Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.

Coding: Both J1700A and J1700C would be **coded 1, yes**.

Rationale: Ms. P. had a fall-related fracture less than 1 month prior to entry.

J1900: Number of Falls in the last 6 months with or without Injury (180-Day Look-back)

J1900. Number of Falls in the last 6 months with or without Injury	
	↓ Enter Codes in Boxes
Coding: 0. None 1. One 2. Two or more	<input type="checkbox"/> A. No injury – no evidence of any pain, injury or change in the individual's behavior after the fall as reported by the individual/ caregiver.
	<input type="checkbox"/> B. Injury (except major) – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the individual to complain of pain
	<input type="checkbox"/> C. Major injury – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definitions

Injury related to a fall- Any documented injury that occurred as a direct result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

Injury (except major) - Includes skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the individual to complain of pain.

Major injury - Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among older adults.
- Falls may result in serious injury, especially hip fractures.
- Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

Planning for Care

- Identification of individuals who are at high risk of falling is a top priority for planning of care.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions,
- A fall should stimulate evaluation of the individual's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment.

Steps for Assessment

1. Review the medical record, if available, for any falls occurring in the last 6 months.
2. Review all available sources for any fall occurring in the last 6 months, no matter whether it occurred while away from the community setting, in an acute hospital, or in a facility. Include medical records generated in any health care setting in the last 6 months. All relevant records received from acute and post-acute facilities where the individual may have been admitted during the look-back period should be reviewed for evidence of one or more falls.
3. Review any incident reports for falls and level of injury.
4. Ask the individual and caregivers about falls during the look-back period. Individual and caregiver reports should be captured here, whether or not these incidents are documented in the medical record.

Coding Instructions for J1900

- Determine the number of falls that occurred in the last 6 months and code the level of fall-related injury for each.
- If the individual has multiple injuries in a single fall, code the fall for the highest level of injury.

Coding Instructions for J1900A, No Injury

- **Code 0, none:** if the individual had no falls without injury in the last 6 months.
- **Code 1, one:** if the individual had one fall without injury in the last 6 months.
- **Code 2, two or more:** if the individual had two or more falls in the last 6 months.

Coding Instructions for J1900B, Injury (Except Major)

- **Code 0, none:** if the individual had no falls with injury (except major) in the last 6 months.
- **Code 1, one:** if the individual had one fall with injury (except major) in the last 6 months.
- **Code 2, two or more:** if the individual had two or more falls with injury (except major) in the last 6 months.

Coding Instructions for J1900C, Major Injury

- **Code 0, none:** if the individual had no falls with major injury in the last 6 months.
- **Code 1, one:** if the individual had one fall with major injury in the last 6 months.
- **Code 2, two or more:** if the individual had two or more falls with major injury in the last 6 months.

Examples

1. Her caregiver note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her wheelchair, an assessment was completed that indicated no injury.

Coding: J1900A would be coded 1, one fall with no injury.

Rationale: Slipping to the floor is a fall. No injury was noted.

2. Ms. Z. went out with her family for dinner. When they returned, her son stated that while at the restaurant, she went to the bathroom and the door closed against her walker, causing her to lose balance and fall. No injury was noted when she returned from dinner.

Coding: J1900A would be coded 1, one fall with no injury.

Rationale: Falls occurring even away from the home are captured here.

3. While being treated in the hospital for pneumonia, climbed over his bedrails and fell to the floor. He had a cut over his left eye and some swelling on his arm. X-rays revealed no injury and neurological checks revealed no changes in mental status.

Coding: J1900B would be coded 1, one fall with injury (except major)

Rationale: Lacerations and swelling without fracture are classified as injury (except major).

4. An individual fell, lacerated his head, and a CT scan indicated a subdural hematoma.

Coding: J1900C would be coded as 1, one fall with major injury.

Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall.

J2000: Prior Surgery

J2000. Prior Surgery	
Enter Code	Did the individual have major surgery during the 100 days prior to this assessment?
<input type="text"/>	0. No 1. Yes 8. Unknown

Item Rationale

Health-related Quality of Life

• A recent history of major surgery during the 100 days prior to this assessment can affect an individual's care and recovery.

Planning for Care

• This item identifies whether the individual has had major surgery during the 100 days prior to this assessment. A recent history of major surgery can affect an individual's care and recovery.

J2000: Prior Surgery (cont.)

Steps for Assessment

1. Ask the individual and his or her family or significant other about any surgical procedures in the 100 days prior to admission.
2. Review the individual's medical record to determine whether the individual had major surgery during the 100 days prior to admission.

Medical record sources include medical records received from facilities where the individual received health care during the previous 100 days, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions

- **Code 0, No**, if the individual did not have major surgery during the 100 days prior to the assessment.
- **Code 1, Yes**, if the individual had major surgery during the 100 days prior to the assessment.
- **Code 8, Unknown**, if it is unknown or cannot be determined whether the individual had major surgery during the 100 days prior to the assessment.

Coding Tips

- Generally, major surgery for item J2000 refers to a procedure that meets **all** the following criteria:
 1. the individual was an inpatient in an acute care hospital for at least one day in the 100 days prior to the assessment,
 2. the individual had general anesthesia during the procedure, **and**
 3. the surgery carried some degree of risk to the individual's life or the potential for severe disability.

Examples

1. Mrs. T reports that she required surgical removal of a skin tag from her neck a month and a half ago. She had the procedure as an outpatient. Mrs. T reports no other surgeries in the last 100 days.

Coding: J2000 would be coded **0, No**.

Rationale: Mrs. T's skin tag removal surgery did not require an acute care inpatient stay, and general anesthesia was not administered; therefore, the skin tag removal does not meet all three required criteria to be coded as major surgery. Mrs. T did not have any other surgeries in the last 100 days.

2. Mr. A's wife informs his nurse that six months ago he was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis. Mr. A's wife reports Mr. A has had no other surgeries since the time of his bowel resection.

Coding: J2000 would be coded **0, No**.

Rationale: Bowel resection is a major surgery requiring general anesthesia and has some degree of risk for death or severe disability. Mr. A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and Mr. A has not undergone any surgery since that time.

J2000: Prior Surgery (cont.)

3. Mrs. G. reports she is receiving Home Health nursing for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy for which she received general anesthesia. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record. The assessment is being performed two days post discharge from the acute care hospitalization. She reports she was in the hospitalization for six days.

Coding: J2000 would be coded **1, Yes.**

Rationale: Mrs. G underwent a complicated cholecystectomy for which she required general anesthesia. She additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability. Mrs. G required a six-day hospitalization that occurred in the last 100 days.

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Intent: The items in this section are intended to assess the many conditions that could affect the individual’s ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches.

K0100: Swallowing Disorder

K0100. Swallowing Disorder	
Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
<input type="checkbox"/>	A. Loss of liquids/solids from mouth when eating or drinking
<input type="checkbox"/>	B. Holding food in mouth/cheeks or residual food in mouth after meals
<input type="checkbox"/>	C. Coughing or choking during meals or when swallowing medications
<input type="checkbox"/>	D. Complaints of difficulty or pain with swallowing
<input type="checkbox"/>	Z. None of the above

Item Rationale

Health-related Quality of Life

- The ability to swallow safely can be affected by many disease processes and functional decline.
- Alterations in the ability to swallow can result in choking and aspiration, which can increase the individual’s risk for malnutrition, dehydration, and aspiration pneumonia.

Planning for Care

- When necessary, the individual should be evaluated by the physician, speech language pathologist and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids.

- Assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modifications or other interventions (e.g., tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the individual.

Steps for Assessment

1. Ask the individual or the caregiver if the individual has had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D. When possible, observe the individual during meals or at other times when he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorders are exhibited.
2. Interview the caregiver and ask if any of the four listed symptoms were evident during the 7-day look-back period.

- Review the medical record, if available, including nursing, physician, dietician, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.

Coding Instructions

Check all that apply.

- K0100A, loss of liquids/solids from mouth when eating or drinking.** When the individual has food or liquid in his or her mouth, the food or liquid dribbles down chin or falls out of the mouth.
- K0100B, holding food in mouth/cheeks or residual food in mouth after meals.** Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because individual failed to empty mouth completely.
- K0100C, coughing or choking during meals or when swallowing medications.** The individual may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The individual may frequently complain of food or medications “going down the wrong way.”
- K0100D, complaints of difficulty or pain with swallowing.** Individual may refuse food because it is painful or difficult to swallow.
- K0100Z, none of the above:** if none of the K0100A through K0100D signs or symptoms were present during the 7-day look-back period.

Coding Tips

- Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
- Code even if the symptom occurred only once in the 7-day look-back period.

K0200: Height and Weight (30-Day Look-back for Weight)

K0200. Height and Weight – While measuring, if the number is X.1 – X.4, round down; X.5 or greater round up	
<input type="text"/> <input type="text"/> inches	A. Height (in inches). Record most recent height measure.
<input type="text"/> <input type="text"/> <input type="text"/>	B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.). Enter '-' Dash if unable to assess.

Definitions

5 percent Weight loss in 30 Days – Start with the individual’s weight closest to 30 days ago and multiply it by .95 (or 95 percent). The resulting figure represents a 5 percent loss from the weight 30 days ago. If the individual’s current weight is equal to or less than the resulting figure, the individual has lost more than 5 percent body weight.

10 percent Weight loss in 180 Days – Start with the individual’s weight closest to 180 days ago and multiply it by .90 (or 90 percent). The resulting figure represents a 10 percent loss from the weight 180 days ago. If the individual’s current weight is equal to or less than the resulting figure, the individual has lost more than 10 percent body weight.

Physician prescribed weight-loss regimen – A weight reduction plan ordered by the individual’s physician with the care plan goal of weight reduction. The regimen may employ a calorie-restricted diet or other weight loss diets and exercise. When a physician has ordered diuretics and weight loss is expected to occur it is included under this definition. It is important that weight loss is intentional.

Body mass index (BMI) – Number calculated from an individual’s weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit

http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Item Rationale

Health-related Quality of Life

- Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life.

Planning for Care

- Height and weight measurements assist with assessing the individual’s nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time. The measurement of weight is one guide for determining nutritional status.

Steps for Assessment for K0200A, Height

1. Measure and record height in inches at the time of the Initial and Annual Assessment.
2. Measure height in accordance with current standards of practice (shoes off, etc.).
3. If an individual cannot stand to obtain a current height, height can be measured with the individual lying flat in bed.

Coding Instructions for K0200A, Height

- Record height to the nearest whole inch.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches.

Steps for Assessment for K0200B, Weight (30-Day Look-back)

1. Measure and record weight in pounds at the time of the Initial and Annual Assessment.
2. If unable to weigh the individual, obtain a medical record that has a recent weight

measurement or ask the individual or caregiver and record that measurement.

3. Measure weight in accordance with current standards of clinical practice (e.g., after voiding, before meal).

Coding Instructions for K0200B, Weight

- Use mathematical rounding (i.e., If weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If an individual cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-).

K0300: Weight Loss ® (180-Day Look-back)

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

Definitions

Physician-Prescribed Weight-Loss Regimen- A weight reduction plan ordered by the individual's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. When a physician has ordered diuretics and weight loss is expected to occur it is included under this definition. It is important that weight loss is intentional.

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Weight loss may be an important indicator of a change in the individual's health status or environment.
- If significant unplanned change in weight is noted, the nurse assessor should encourage the individual to make a physician appointment so the individual can be assessed for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status.

For an Initial Assessment

- Obtain weight from the medical record, if available, or ask the individual or caregiver about weight loss over the past 30 and 180 days.
- If the weight at the Initial Assessment is less than the previous weight, calculate the percentage of weight loss.

For Subsequent Assessments

- Compare the individual's weight to the weight recorded on the previous assessment, or to reported previous weight. If the weight is less, calculate the percentage of weight loss.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight loss calculation.

- **Code 0, no or unknown:** if the individual has not experienced weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days or if information about prior weight is not available.
- **Code 1, yes on physician-prescribed weight loss regimen:** if the individual has experienced a weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where an individual has a weight loss of 5 percent or more in 30 days or 10 percent or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as a **1**.
- **Code 2, yes, not on physician-prescribed weight-loss regimen:** if the individual has experienced a weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight loss was not planned and prescribed by a physician.

Coding Tips

- Weight changes of 5 percent in 1 month, 7.5 percent in 3 months, or 10 percent in 6 months should prompt a thorough assessment of the individual's nutritional status.
- To code K0300 as **1, yes**, the expressed goal of the diet must be inducing weight loss or the expected weight loss of edema through the use of diuretics.
- On occasion, an individual with normal BMI or even low BMI is placed on a diabetic or otherwise calorie-restricted diet. In this instance, the intent of the diet is not to induce weight loss, and it would not be considered a physician-ordered weight-loss regimen.

Examples

1. Mrs. J has been on a physician ordered calorie-restricted diet for the past year. She and her physician agreed to a plan of weight reduction. Her current weight is 169 lbs. Her weight 30 days ago was 172 lbs. Her weight 180 days ago was 192 lbs.

Coding: K0300 would be **coded 1, yes, on physician-prescribed weight-loss regimen.**

Rationale:

- 30-day calculation: $172 \times 0.95 = 163.4$. Since the individual's current weight of 169 lbs. is more than 163.4 lbs., which is the 5 percent point, she **has not** lost 5 percent body weight in the last 30 days.
- 180-day calculation: $192 \times .90 = 172.8$. Since the individual's current weight of 169 lbs. *is* less than 172.8 lbs., which is the 10 percent point, she **has** lost 10 percent or more of body weight in the last 180 days.


2. Mr. S has had increasing need for assistance with eating over the past 6 months. His current weight is 195 lbs. His weight 30 days ago was 197 lbs. His weight 180 days ago was 185 lbs.

Coding: K0300 would be **coded 0, no.**

Rationale:

- 30-day calculation: $197 \times 0.95 = 187.15$. Because the individual's current weight of 195 lbs. is more than 187.15 lbs., which is the 5 percent point, he has not lost 5 percent body weight in the last 30 days.
- 180-day calculation: Mr. S's current weight of 195 lbs. is greater than his weight 180 days ago, so there is no need to calculate his weight loss. He has gained weight over this time period.

K0310: Weight Gain (180-Day Look-back)

K0310. Weight Gain	
	Gain of 5% or more in the last month or gain of 10% or more in last 6 months
	0. No or unknown
	1. Yes, on physician-prescribed weight-gain regimen
	2. Yes, not on physician-prescribed weight-gain regimen

Item Rationale

Health-related Quality of Life

- Weight gain can result in debility and adversely affect health, safety, and quality of life.

Planning for Care

- Weight gain may be an important indicator of a change in the individual's health status or environment
- If significant weight gain is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., steroids), or changed fluid volume status.
- Weight gain should be monitored on a continuing basis, assessed and care planned.

For an Initial Assessment

- Obtain weight from the medical record, if available, or ask the individual or caregiver about weight gain over the past 30 and 180 days.
- If the weight at the Initial Assessment is less than the previous weight, calculate the percentage of weight gain.

For Subsequent Assessments

- Compare the individual's weight to the weight recorded on the previous assessment, or to reported previous weight. If the weight is more, calculate the percentage of weight gain.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight gain calculation.

- **Code 0, no or unknown:** if the individual has not experienced weight loss of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days or if information about prior weight is not available.
- **Code 1, yes on physician-prescribed weight gain regimen:** if the individual has experienced a weight gain of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where an individual has a weight gain of 5 percent or more in 30 days or 10 percent or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as a **1**.
- **Code 2, yes, not on physician-prescribed weight-gain regimen:** if the individual has experienced a weight gain of 5 percent or more in the past 30 days or 10 percent or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

Coding Tips

- Weight changes of 5 percent in 1 month, 7.5 percent in 3 months, or 10 percent in 6 months should prompt a thorough assessment of the individual's nutritional status.
- To code K0310 as **1, yes**, the expressed goal of the weight gain diet must be documented.

K0510: Nutritional Approaches

K0510. Nutritional Approaches	
↓ Check all of the following nutritional approaches that were performed during the last 7 days	
<input type="checkbox"/>	A. Parenteral/IV feeding
<input type="checkbox"/>	B. Feeding-tube – nasogastric or abdominal (PEG)
<input type="checkbox"/>	C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
<input type="checkbox"/>	D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
<input type="checkbox"/>	Z. None of the above

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.

Mechanically Altered Diet – A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

Therapeutic diet – A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium, potassium) (ADA, 2011).

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal (e.g., mechanically altered food) or 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 individual's clinical condition may potentially benefit from the various nutritional approaches included here.

Planning for Care

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

Steps for Assessment

1. Review the medical record, if available, to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.
2. Ask the individual or caregiver if any of the listed nutritional approaches were received by the individual during the 7-day look-back period.
3. Observe the individual to determine if any of the listed nutritional approaches were received by the individual during the 7-day look-back period.

Coding Instructions

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

- **K0510A**, parenteral/IV feeding ®
- **K0510B**, feeding tube- nasogastric or abdominal (PEG) ®
- **K0510C**, mechanically altered diet- require change in texture of food or liquids (e.g., pureed food, thickened liquids)

- **K0510D**, therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- **K0510Z**, none of the above

Coding Tips

- Parenteral/IV feeding—The following fluids may be included **when they are administered for nutrition or hydration**:
 - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
 - IV fluids running at KVO (Keep Vein Open)
 - IV fluids contained in IV Piggybacks
 - Hypodermoclysis and subcutaneous ports in hydration therapy
 - IV fluids can be coded in K0510 if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration.
 - **Do NOT include:**
 - IV Medications—**Code these in (O0100H) IV medication.**
 - IV fluids used to reconstitute and/or dilute medications for IV administration. IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
 - IV fluids administered solely as flushes.
 - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.
- Enteral feeding formulas:
 - Should not be coded as a mechanically altered diet.
 - Should only be coded as **K0510D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g., enteral formulas specific to individuals with diabetes.

Coding Tips for K0510D

- Therapeutic diets are not defined by the content of what is provided or when it is served, but *why* the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be *part* of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g., supplement for protein-calorie malnutrition).

Example

1. Mr. J is receiving an antibiotic in 100 cc of normal saline via IV. He has a UTI, no fever, and documented adequate fluid intake. He is placed on a plan to ensure adequate hydration.

Coding: K0510A would **NOT be checked**. The IV medication would be coded at **IV Medications** item (O0100H).

Rationale: Although he received the fluid needed to reconstitute the antibiotic, there is no documentation to support a need for additional fluid intake.

K0710: percent Intake by Artificial Route

Complete only if K0510A or K0510B is checked.

K0710. Percent Intake by Artificial Route – Complete K0710 only if K0510A or K0510B is checked	
Enter <input type="text"/> Code	A. Proportion of total calories the individual received through parenteral or tube feeding during entire 7 days 1. 25% or less 2. 26–50% 3. 51% or more
Enter <input type="text"/> Code	B. Average fluid intake per day by IV or tube feeding during entire 7 days 1. 500 cc/day or less 2. 501 cc/day or more

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal, such as parenteral/IV or feeding tubes, can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.

Planning for Care

- The proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration.
- Periodic reassessment is necessary to facilitate transition to increased oral intake.

K0710A, Proportion of Total Calories the Individual Received through Parental or Tube Feedings ®

Steps for Assessment

1. Review intake records, if available, to determine actual intake through parenteral or tube feeding routes.
2. If records are not available, talk to the individual or the caregiver to determine actual intake by mouth and through parenteral or tube feeding routes.

Coding Instructions

Calculate proportion of total calories received through parenteral or tube feeding routes.

- Select the best response:
 1. 25 percent or less
 2. 26 percent to 50 percent
 3. 51 percent or more

Example

1. Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H was discharged home with a feeding tube after surgery. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past 7 days, he has been receiving tube feedings for nutritional supplementation. His calories per day are totaled as follows:

	Oral	Tube
Sun.	500	2,000
Mon.	250	2,250
Tues.	250	2,250
Wed.	350	2,250
Thurs.	500	2,000
Fri.	250	2,250
Sat.	350	2,000
Total	2,450	15,000

Coding: K0710A would be coded **3, 51 percent or more**.

Rationale:

- Total Oral intake is 2,450 calories
- Total Tube intake is 15,000 calories Total calories is $2,450 + 15,000 = 17,450$
Calculation of the percentage of total calories by tube feeding: $15,000/17,450 = .859 \times 100 = 85.9$ percent Mr. H received 85.9 percent of his calories by tube feeding, therefore K0710A code **3, 51 percent or more** is correct.

K0710B, Average Fluid Intake per Day by IV or Tube Feeding ®

Steps for Assessment

1. Review intake records, if available, from the last 7 days.
2. If records are not available, talk to the individual or the caregiver to determine the fluid intake.
3. Add up the total amount of fluid received each day by IV and/or tube feedings only.
4. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day.
5. Divide by 7 even if the individual did not receive IV fluids and/or tube feeding on each of the 7 days.

Coding Instructions

Code for the average number of cc's of fluid the individual received per day by IV or tube feeding. Record what was actually received by the individual, not what was ordered.

- **Code 1:** 500 cc/day or less
- **Code 2:** 501 cc/day or more

Example

1. Calculation for Average Daily Fluid Intake

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

Sun.	1250cc
Mon.	775cc
Tues.	925cc
Wed.	1200cc
Thurs.	1200cc
Fri.	500cc
Sat.	450cc
Total	6,300cc

Coding: K0710B would be coded **2, 501cc/day or more**.

Rationale: The total fluid intake by supplemental tube feedings = 6,300 cc. 6,300 cc divided by 7 days = 900 cc/day 900 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more** is correct.

SECTION L: ORAL/DENTAL STATUS

Intent: This item is intended to record any dental problems present in the 7-day look-back period.

L0200: Dental

L0200. Dental	
↓ Check all that apply	
<input type="checkbox"/>	A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)
<input type="checkbox"/>	B. No natural teeth or tooth fragment(s) (edentulous)
<input type="checkbox"/>	C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)
<input type="checkbox"/>	D. Obvious or likely cavity or broken natural teeth
<input type="checkbox"/>	E. Inflamed or bleeding gums or loose natural teeth
<input type="checkbox"/>	F. Mouth or facial pain, discomfort or difficulty with chewing
<input type="checkbox"/>	G. Unable to examine
<input type="checkbox"/>	Z. None of the above were present

Definitions

Cavity - A tooth with a discolored hole or area of decay that has debris in it.

Broken Natural Teeth or Tooth Fragment - A very large cavity, tooth broken off or decayed to gum line, or broken teeth (from a fall or trauma).

Oral Lesions - A discolored area of tissue (red, white, yellow, or darkened) on the lips, gums, tongue, palate, cheek lining, or throat.

Oral Mass - A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.

Ulcer/injury - Mouth sore, blister or eroded area of tissue on any oral surface.

Item Rationale

Health-related Quality of Life

- Poor oral health has a negative impact on:
 - quality of life
 - overall health
 - nutritional status
- Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Planning for Care

- Assessing dental status can help identify individuals who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Steps for Assessment

1. Ask the individual about the presence of chewing problems, or mouth or facial pain/discomfort.
2. Ask the individual and/or caregiver whether the individual has or recently had dentures or partials.
3. If the individual has dentures or partials, examine for loose fit. Ask him or her to remove, and with a gloved hand, examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment.
4. Conduct exam of the individual's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces, including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.
5. If the individual is unable to self-report, then, if possible, observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.
6. Oral examination in individuals who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these individuals.

Coding Instructions

- **Check L0200A, broken or loosely fitting full or partial denture:** if the denture or partial is chipped cracked, uncleanable, or loose. A denture is coded as loose if the individual complains that it is loose, the denture visibly moves when the individual opens his or her mouth, or the denture moves when the individual tries to talk.
- **Check L0200B, no natural teeth or tooth fragment(s) (edentulous):** if the individual is edentulous or lacks all natural teeth or parts of teeth.
- **Check L0200C, abnormal mouth tissue (ulcers/injuries, masses, oral lesions):** Select if any ulcer/injury, mass, or oral lesion is noted on any oral surface.
- **Check L0200D, obvious or likely cavity or broken natural teeth:** if any cavity or broken tooth is seen.
- **Check L0200E, inflamed or bleeding gums or loose natural teeth:** if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
- **Check L0200F, mouth or facial pain or discomfort with chewing:** if the individual reports any pain in the mouth or face, or discomfort with chewing.
- **Check L0200G, unable to examine:** if the individual's mouth cannot be examined.
- **Check L0200Z, none of the above:** if none of conditions A through F is present.

Coding Tips

- Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.

Pediatric Tips

- **Check L0200 B**, for an infant with no teeth.
- **Check L0200 F**, for a child with teething pain.
- **Check L0200 C, E, and/or F**, (all that apply) for a child with Oral Candidiasis (thrush) or stomatitis if it occurred in the 7-day look-back period.

SECTION M: SKIN CONDITIONS

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each individual's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program.

M0100: Determination of Pressure Ulcer/Injury Risk

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer/Injury Risk	
↓ Check all that apply	
<input type="checkbox"/>	A. Individual has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
<input type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above

Definitions

Pressure Ulcer/Injury Risk Factors- Examples of risk factors include immobility and decreased functional ability, co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; impaired diffuse or localized blood flow; individual's refusal of care and treatments; cognitive impairment; exposure of skin to urinary and fecal incontinence; under nutrition, malnutrition, and hydration deficits; and a healed ulcer/injury.

Pressure Ulcer/Injury Risk Tools- Screening tools that are designed to help identify individuals who might develop a pressure ulcer/injury. Common risk assessment tools are the Norton Scale and the Braden Scale for Predicting Pressure Ulcer/injury Risk.

Health-related Quality of Life

- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force and friction are important contributors to pressure ulcer/injury development.
- The underlying health of an individual's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.
- Additional external factors, such as excess moisture and tissue exposure to urine or feces, can increase risk.

Planning for Care

- The plan of care should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate based on the individual's needs.
- Throughout this section, terminology referring to “healed” versus “unhealed” ulcers/injuries refers to whether or not the ulcer/injury is “closed” versus “open.” When considering this, recognize that Stage 1, Suspected Deep Tissue Injury (DTI), and unstageable pressure ulcers/injuries although “closed,” (i.e. may be covered with tissue, eschar, slough, etc.) would not be considered “healed.”

Steps for Assessment

1. Review the medical record, if available, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments.
2. Examine the individual and determine whether any ulcers/injuries, scars, or non-removable dressings/devices are present. Check key areas for pressure ulcer/injury development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also check bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to friction (e.g., ears from oxygen tubing).

Coding Instructions

For this item, check all that apply:

- **Check A if individual has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device.** Review descriptions of pressure ulcers/injuries and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.
- **Check B if a formal assessment has been completed.** An example of an established pressure ulcer/injury risk tool is the Braden Scale for Predicting Pressure Sore Risk
- **Check C if the individual's risk for pressure ulcer/injury development is based on clinical assessment.** A clinical assessment could include a head-to-toe physical examination of the skin and/or observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following:
 - impaired/decreased mobility and decreased functional ability, co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; drugs, such as steroids, that may affect wound healing;
 - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
 - Individual's refusal of some aspects of care and treatment;
 - cognitive impairment;
 - urinary and fecal incontinence;
 - under nutrition, malnutrition, and hydration deficits; and
 - healed Stage 3 or 4 pressure ulcers/injuries, which are more likely to have recurrent breakdown.

- Check Z if none of the above apply.

M0150: Risk of Pressure Ulcers/Injuries

M0150. Risk of Pressure Ulcers/Injuries	
Enter Code <input type="checkbox"/>	Is this individual at risk of developing pressure ulcers/injuries? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

It is important to recognize and evaluate each individual's risk factors and to identify and evaluate all areas at risk of constant pressure.

Planning for Care

The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

Steps for Assessment

1. Based on the item(s) reviewed for M0100, determine if the individual is at risk for developing a pressure ulcer/injury.
2. If the medical record or clinical assessment reveals that the individual currently has a Stage 1 or greater pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the individual is at risk for worsening or new pressure ulcers/injuries.
3. Review formal risk assessment tools, if available, to determine the individual's "risk score."
4. Review the components of the clinical assessment conducted for evidence of pressure ulcer/injury risk.

Coding Instructions

- **Code 0, no:** if the individual is not at risk for developing pressure ulcers/injuries based on a review of items in M0100.
- **Code 1, yes:** if the individual is at risk of developing pressure ulcers/injuries based on information gathered for M0100.

M0210: Unhealed Pressure Ulcers/Injuries

M0210. Unhealed Pressure Ulcers/Injuries	
Enter Code	Does this individual have one or more unhealed pressure ulcers/injuries?
<input type="checkbox"/>	0. No → skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Definitions

Pressure Ulcer/Injury – A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

Healed Pressure Ulcer/Injury - Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries and other wounds or lesions affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The pressure ulcer/injury definitions incorporate those recommended by the National Pressure Ulcer/injury Advisory Panel (NPUAP) 2016 Pressure Injury Staging System.
- An existing pressure ulcer/injury identifies individuals at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.
- Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.
- The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen.

Steps for Assessment

1. Review the medical record, if available, including skin care assessments or other skin tracking forms.
2. Examine the individual and determine whether any ulcers/injuries are present.
 - Key areas for pressure ulcer/injury development include sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess friction, are also at risk for pressure ulcers/injuries.
 - Without a full body skin assessment, a pressure ulcer/injury can be missed.

3. Examine the individual in a well-lit room. Adequate lighting is important for detecting skin changes.
4. For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage.
5. Identify any known or likely unstageable pressure ulcers/injuries.

Coding Instructions

Code based on the presence of any pressure ulcer/injury/injury (regardless of stage) in the past 7 days.

- **Code 0, no:** if the individual did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, **Number of Venous and Arterial Ulcers**.
- **Code 1, yes:** if the individual had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**.

Coding Tips

- If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury.
- Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue.
- Mucosal pressure ulcers are not staged using the skin pressure ulcer/injury/injury staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here.
- If a pressure ulcer is surgically repaired with a flap or graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.
- If an individual with diabetes mellitus (DM) has a heel ulcer/injury from pressure and the ulcer/injury is present in the 7-day look-back period, **code 1** and proceed to code in M0300 as appropriate for the pressure ulcer/injury.
- If an individual with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal and the ulcer is present in the 7-day look-back period, **code 0** and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the ulcer when it is in this location.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have home health staff who are trained in wound assessment and who are able to distinguish scabs from eschar
- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least

superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.

- If an individual had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment.

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer/injury/injury, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

1. Observe the base of any pressure ulcers present to determine the depth of tissue layers involved.
2. Ulcer/Injury staging should be based on the ulcer's deepest visible anatomical level. Review the history of each pressure ulcer in the medical record, if available. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage.
3. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.
4. Clinical standards do not support reverse staging or backstaging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.
3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at <http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg>.
4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
4. A pressure injury with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure injury. It should be coded as unstageable, as illustrated at

<http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg>.

5. Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. “Known” refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.
6. Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. “Known” refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.

M0300A: Stage 1 Pressure Ulcers/Injuries ®

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number <input type="text"/>	<p>A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues</p> <p>1. Number of Stage 1 pressure injuries</p>

Definitions

Stage 1 pressure ulcer/injury- An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameter: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer/injury may appear with persistent red, blue or purple hues.

Non-Blanchable- Reddened areas of tissue that do not turn white or pale when firmly pressed with a finger.

Item Rationale

Health-related Quality of Care

- Stage 1 pressure injuries may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage.

Planning for Care

- Development of a Stage 1 pressure injury should be one of multiple factors that initiate pressure ulcer/injury prevention interventions.

Steps for Assessment

Identify all Stage 1 pressure ulcers/injuries that are currently present.

Coding Instructions for M0300A

- Enter the number of Stage 1 pressure ulcers/injuries that are currently present.
- Enter 0 if no Stage 1 pressure ulcers/injuries are present.

Coding Tips

Pressure ulcers/injuries with suspected deep tissue injury should **not** be coded as Stage 1 pressure ulcers/injuries. They should be coded as unstageable pressure ulcers/injuries due to suspected deep tissue injury as **Unstageable - Deep tissue** item (M0300G).

M0300B: Stage 2 Pressure Ulcers®

<p>Enter Number <input type="text"/></p> <p>Enter Number <input type="text"/></p>	<p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> <p>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
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Definitions

Stage 2 Pressure Ulcer/Injury- Partial thickness loss of dermis presenting as a shallow open ulcer/injury with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.

Item Rationale

Health-related Quality of Life

- Stage 2 pressure ulcers/injuries may worsen without proper interventions.
- These individuals are at risk for further complications or skin injury.

Planning for Care

- Most Stage 2 pressure ulcers/injuries should heal in a reasonable time frame (e.g., 60 days).
- Stage 2 pressure ulcers/injuries are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers/injuries may be more likely to heal with treatment than a higher stage pressure ulcer/injury.
- The plan of care should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

Steps for Assessment

Identify all Stage 2 pressure ulcers/injuries that are currently present.

Coding Instructions for M0300B

- **Enter the number** of pressure ulcers/injuries that are currently present and whose deepest anatomical stage is Stage 2.
- **Enter 0** if no Stage 2 pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300C).

Coding Tip

- Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.
- Do not code skin tears, tape burns, moisture associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.

M0300C: Stage 3 Pressure Ulcers/Injuries ®

Enter Number <input type="text"/>	<p>C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling</p> <p>1. Number of Stage 3 pressure ulcers</p>
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Definition

Stage 3 Pressure Ulcer/Injury- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers/injuries at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or caregiver intensive.
- An existing pressure ulcer/injury may put individuals at risk for further complications or skin

injury. The nurse assessor should communicate findings with the individual's physician.

- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration

Steps for Assessment

- Identify all Stage 3 pressure ulcers/injuries currently present.

Coding Instructions for M0300C

- **Enter the number** of pressure ulcers/injuries that are currently present and whose deepest anatomical stage is Stage 3. **Enter 0** if no Stage 3 pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressures Ulcers/Injuries at Each Stage** item (M0300D).

Coding Tips

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers/injuries can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers/injuries.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer/injury.

Example

1. Ms. T develops a Stage 2 pressure ulcer/injury. She is hospitalized due to pneumonia for 8 days and returns home with a Stage 3 pressure ulcer/injury in the same location.

Coding: The pressure ulcer/injury/injury would be coded as **Stage 3**.

Rationale: Even though she had a pressure ulcer/injury in the same anatomical location prior to hospitalization, because it worsened to a Stage 3 during hospitalization it should be coded as a Stage 3.

M0300D: Stage 4 Pressure Ulcers/Injuries ®

<p>Enter Number</p> <input type="text"/>	<p>D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</p> <p>1. Number of Stage 4 pressure ulcers</p>
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Definitions

Stage 4 Pressure Ulcer//Injury- Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

Tunneling- A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

Undermining- The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer/injury is larger at its based than at the skin surface.

Item Rationale

Health-related Quality of Life

- Pressure ulcer/injury affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers/injuries at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventive care.
- An existing pressure ulcer/injury may put individuals at risk for further complications or skin injury. The nurse assessor should communicate findings with the individual's physician.

Steps for Assessment

- Identify all Stage 4 pressure ulcers/injuries currently present.

Coding Instructions for M0300D

- **Enter the number** of pressure ulcers/injuries that are currently present and whose deepest anatomical stage is Stage 4.
- **Enter 0** if no Stage 4 pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300E).

Coding Tips

- The depth of a Stage 4 pressure ulcer/injury varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers/injuries can be shallow.
- Stage 4 pressure ulcers/injuries can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

M0300E: Unstageable Pressure Ulcers/Injuries Due to Non-removable Dressing/Device

<p>Enter Number</p> <input type="text"/>	<p>E. Unstageable – Non-removable dressing/device: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable e -Slough and/or eschar</p>
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Definition

Non-removable dressing/device- Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Item Rationale

Health-related Quality of Life

Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for individuals because it may limit activity and may be painful.

Planning for Care

Although the pressure ulcer/injury itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the individual is monitored for adequate pain control.

Steps for Assessment

1. Review the medical record, if available, for documentation of a pressure ulcer/injury covered by a non-removable dressing.
2. Determine the number of documented pressure ulcer/injuries covered by a non-removable

dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.

Coding Instructions for M0300E

- Enter the number of pressure ulcers/injuries that are unstageable due to non-removable dressing/device.
- Enter 0 if no unstageable pressure ulcers/injuries are present and skip to **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300F).

M0300F: Unstageable Pressure Ulcers Due to Slough and/or Eschar ®

<p>Enter Number</p> <input type="text"/>	<p>F. Unstageable – Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</p>
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Definitions

Slough tissue- Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

Eschar tissue- Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

Fluctuance- Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for individuals because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Visualization of the wound bed is necessary for accurate staging.
- The presence of pressure ulcers/injuries and other skin changes should be accounted for in the interdisciplinary care plan.
- Pressure ulcers/injuries that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrosis and dead tissue and restaging once the necrotic tissue is removed.

Steps for Assessment

- Determine the number of pressure ulcers/injuries that are unstageable due to slough/eschar.

Coding Instructions for M0300F

- **Enter the number** of pressure ulcers/injuries that are unstageable due to slough and/or eschar.
- **Enter 0** if no unstageable pressure ulcers/injuries are present and skip to M0300G, Unstageable – Deep tissue injury.

Coding Tips

- Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the individual’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

Example

1. Mr. Z has a sacral pressure ulcer/injury that is 100 percent covered with black necrotic eschar.

Coding: The pressure ulcer/injury would be **coded as unstageable** on **Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage** item (M0300F1).

Rationale: The pressure ulcer/injury stage is not observable because it is covered with eschar.

M0300G: Unstageable Pressure Injuries Due to Suspected Deep Tissue Injury

Enter Number <input type="text"/>	G. Unstageable – Deep tissue injury: 1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers
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Definition

Suspected deep injury tissue- Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer/injury even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing an individual's ability to avoid, as well as recover from, pressure (as well as all) wounds/injuries. Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative

Planning for Care

- Deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

Steps for Assessment

- Determine the number of pressure ulcers/injuries that are unstageable due to suspected deep tissue injury.

Coding Instructions for M0300G

- **Enter the number** of unstageable pressure ulcers/injuries related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury.
- **Enter 0** if no unstageable pressure ulcers/injuries are present and skip to **M1030, Number of Venous and Arterial Ulcers**.

Coding Tips

- Once suspected deep tissue injury has opened to an ulcer/injury, reclassify the ulcer/injury into the appropriate stage. Then code the ulcer/injury for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or

adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here.

M1030: Number of Venous and Arterial Ulcers ®

M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="text"/>	Enter the total number of venous and arterial ulcers present

Definitions

Venous Ulcers- Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

Arterial Ulcers- Ulcers caused by peripheral artery disease, which commonly occur on the tips of toes, top of the foot or distal to the medial malleolus.

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The presence of venous and arterial ulcer/injury should be accounted for in the plan of care.
- This information identifies individuals at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, if available, including skin care flow sheet or other skin tracking form.
2. Examine the individual and determine whether any venous or arterial ulcer/injuries are present.
 - Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (e.g., above the inner and outer ankle area).
 - Key areas for arterial ulcer development include the distal part of the foot, dorsum or top of the foot, or tips of the toes.
 - Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.
 - Arterial ulcers are often painful and have a pale pink wound bed, minimal exudate,

minimal bleeding, and necrotic tissue.

Coding Instructions

Check all that apply in the last 7 days.

Pressure ulcer/injuries coded in M0210 through M0300 should NOT be coded here.

- **Enter the number** of venous and arterial ulcers present.
- **Enter 0:** if there were no venous or arterial ulcers present.

Coding Tips

Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on the wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer/injury. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on the wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer/injury.

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
None of the Above	
<input type="checkbox"/>	Z. None of the above were present

Definitions

Diabetic Foot Ulcers - Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on

load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

Surgical Wounds - Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body.

Open Lesions Other Than Ulcers, Rashes, Cuts - Most typically skin lesions that develop as a result of diseases and conditions such as syphilis and cancer.

Burns (Second or Third Degree) - Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for individuals because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections.

Planning for Care

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

Steps for Assessment

1. Review the medical record, if available, including skin care flow sheets or other skin tracking forms.
 - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

Coding Instructions

Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.

Pressure ulcer/injuries coded in M0210 through M0300 should NOT be coded here.

- **M1040A**, infection of the foot (e.g., cellulitis, purulent drainage) ®
- **M1040B**, diabetic foot ulcers ®
- **M1040C**, other open lesion(s) on the foot (e.g., cuts, fissures)®
- **M1040D**, open lesion(s) other than ulcers, rashes, cuts (e.g., bullous pemphigoid) ®
- **M1040E**, surgical wound(s). This category does not include healed surgical sites and healed

stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.®

- **M1040F**, burn(s)(second or third degree) ®
- **M1040G**, skin tear(s)
- **M1040H**, Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis ([IAD], perspiration, drainage)
- **M1040Z**, none of the above were present

Coding Tips

M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the individual may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his/her feet.
- Do NOT include pressure ulcer/injuries that occur on individuals with diabetes mellitus here. For example, an ulcer/injury caused by pressure on the heel of an individual with diabetes is a pressure ulcer/injury and not a diabetic foot ulcer/injury.

M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MN/LOC, such as wounds, boils, cysts, and vesicles, should be coded in this item.
- Do NOT code rashes, abrasions, or cuts/lacerations here.
- Do NOT code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MN/LOC.

M1040E Surgical Wounds

- This category does not include healed surgical sites and stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1040F Burns (Second or Third Degree)

- Do NOT include first degree burns (changes in skin color only).

M1040G Skin Tears

- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.

M1040H Moisture Associated Skin Damage (MASD)

- MASD is also referred to as maceration and includes incontinence-associated dermatitis, intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis.
- Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.
- MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present.
- MASD with skin erosion has superficial/partial thickness skin loss and may have hyper or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present. Necrosis is not found in MASD.
- If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.
- If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.

Examples

1. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening.

Coding: Check **M1040H**, Moisture Associated Skin Damage (MASD).

Rationale: Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis.

2. Mr. L with diabetes mellitus presents with an ulcer/injury on the heel that is due to pressure.

Coding: This item is not checked at (**M1040B**). This ulcer should be coded where appropriate under Pressure Ulcer items (**M0210-M0300**).

Rationale: Persons with diabetes can still develop pressure ulcers.

3. Mrs. J was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her.

Coding: Check **M1040G**, Skin Tear(s).

Rationale: Mrs. J sustained a skin tear while reaching for a magazine.

M1200: Skin and Ulcer/Injury Treatments

M1200. Skin and Ulcer/Injury Treatments	
↓	Check all that apply
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer/injury care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

Definitions

Pressure Reducing Device(s) - Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, gel or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating.

Turning/Repositioning Program - Includes a consistent program for changing the individual's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the individual's needs.

Nutrition or Hydration Intervention to Manage Skin Problems - Dietary measures received by the individual for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.

Item Rationale

Health-related Quality of Life

- Appropriate prevention and treatment of skin changes and ulcer/injuries reduce complications and promotes healing.

Planning for Care

- These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the plan of care.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

Steps for Assessment

1. Review the medical record, if available, for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for individuals, so check the provider's policies and procedures, if available, and indicate here if administered during the look-back period.
2. Some skin treatments can be determined by observation. For example, observation of the individual's wheelchair and bed will reveal if the individual is using pressure-reducing devices for the bed or wheelchair.

Coding Instructions

Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days.

- **M1200A**, pressure reducing device for chair ®
- **M1200B**, pressure reducing device for bed ®
- **M1200C**, turning/repositioning program ®
- **M1200D**, nutrition or hydration intervention to manage skin problems ®
- **M1200E**, pressure ulcer/injury care ®
- **M1200F**, surgical wound care ®
- **M1200G**, application of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids ®
- **M1200H**, application of ointments/medications other than to feet ®
- **M1200I**, application of dressings to feet (with or without topical medications) ®
- **M1200Z**, none of the above were provided

Coding Tips

M1200A Pressure Reducing Device

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing device should be selected based on the individualized needs of the individual.
- Do NOT include egg crate cushions of any type in this category.
- Do NOT include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the individual's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, other documentation, and caregiver reports should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the individual's diet and determine if the individual is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

M1200E Pressure Ulcer/Injury Care

- Pressure ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (M0300A–G). Examples may include the use of topical dressings; enzymatic, mechanical or surgical debridement; wound irrigations; negative pressure wound therapy (NPWT); and/or hydrotherapy.

M1200F Surgical Wound Care

- Do not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer/injury continues to be coded as a pressure ulcer/injury.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200 G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do NOT code application of non-surgical dressings for pressure ulcer/injury(s) other than to the feet in this item; use Pressure ulcer/injury care item (M1200E).
- Dressings do not have to be applied daily in order to be coded on the assessment. If any dressing meeting the assessment definitions were applied even once during the 7-day look-back period, the assessor should check that item.
- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages,

etc. Non-surgical dressings do not include adhesive bandages (e.g. Band-Aids, wound closure strips).

M1200H Application of Ointments/Medications Other than to Feet

- Do NOT code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure ulcer/injury care.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer/injury other than a pressure ulcer/injury.
- Do not code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure ulcer/injury care.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Example

1. Mrs. G has a diabetic foot ulcer/injury on the right foot, during the past 7 days has had an Unna boot applied once (orders are to reapply the Unna boot dressing every 3 days), and has a pressure reducing mattress and pad for her wheelchair.
Coding: Skin and Ulcer/injury Treatments items (M1200A, M1200B, and M1200I) **would all be checked.**
Rationale: Treatments include pressure reducing mattress and pad in the wheelchair and application of the Unna boot dressing.

SECTION N: MEDICATIONS

Intent: The intent of the items in this section is to record the number of days, during the last 7 days that any type of injection (subcutaneous, intramuscular or intradermal), insulin, or oral medications were received (i.e. administered or taken) by the individual.

N0300: Injections ®

N0300. Injections	
Enter Days <input type="text"/>	Record the number of days that injections of any type were received during the last 7 days If 0 → Skip to N0410, Medications Received

Item Rationale

Health-related Quality of Life

- Frequency of administration of medication via injection can be an indication of stability of an individual's health status and/or complexity of care needs.

Planning for Care

- Monitor for adverse effects of injected medications.
- Although antigens and vaccines are not considered to be medications per se, it is important to track when they are given to monitor for localized or systemic reactions.

Steps for Assessment

1. Review the individual's medication administration records, if available, for the 7-day look-back period.
2. Review documentation, if available, from other health care locations where the individual may have received injections (e.g., flu vaccine in a physician's office).
3. Determine if any medications were received by the individual via injection. If received, determine the number of days during the look-back period they were received.

Coding Instructions

Record the number of days during the 7-day look-back period that the individual received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection.

Insulin injections are counted in this item as well as in Item N0350.

- Count the number of days that the individual received any type of injection (subcutaneous, intramuscular or intradermal).
- Record the number of days that any type of injection (subcutaneous, intramuscular or intradermal) was received in Item N0300.

Coding Tips and Special Populations

- For subcutaneous pumps, code only the number of days that the individual actually required a subcutaneous injection to restart the pump.
- If an antigen or vaccination is provided on day 1, and another vaccine provided on the next day, the number of days the individual received injections would be coded 2 days.
- If two injections were administered on the same day, the number of days the individual received injections would be coded 1 day.
- Do not code Baclofen, epidural and intrathecal pumps here; they are coded under IV medications in O0100H.

Examples

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

Coding: N0300 would be **coded 3**.

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

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

Coding: N0300 would be **coded 1**.

Rationale: She received injections on 1 day during the 7-day look-back period.

N0350: Insulin

N0350. Insulin	
Enter Days <input type="text"/>	A. Insulin injections – Record the number of days that insulin injections were received during the last 7 days
Enter Days <input type="text"/>	B. Orders for insulin – Record the number of days the physician (or authorized assistant or practitioner) changed the individual's insulin orders during the last 7 days

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Orders for insulin may have to change depending on the individual's condition (e.g., fever or other illness) and/or laboratory results.
- Ensure that dosage and time of injections take into account meals, activity, etc., based on an individualized assessment.
- Monitor for adverse effects of insulin injections (e.g., hypoglycemia).
- Monitor HbA1c and blood glucose levels to ensure appropriate amounts of insulin are being administered.

Steps for Assessment

1. Review the individual's medication administration records, if available, for the 7-day look-back period.
2. Determine if the individual received insulin injections during the look-back period.
3. Determine if the individual's insulin orders were changed during the look-back period.
4. Count the number of days that insulin injections were received and/or changed.

Coding Instructions for N0350A

- Enter in Item N0350A, the number of days during the look-back period that insulin injections were received.

Coding Instructions for N0350B

- Enter in Item N0350B, the number of days that the individual's insulin orders were changed during the look-back period.

Coding Tips and Special Populations

- A sliding scale dosage schedule that is written to cover different dosages depending on lab values does not count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- If the sliding scale order is new, discontinued, or is the first sliding scale order for the individual, these days can be counted and coded.

N0410: Medications Received

N0410. Medications Received	
↓ Indicate the number of DAYS the individual received the following medications by pharmacological classification, not how it is used, during the last 7 days. Enter "0" if medication was not received by the individual during the last 7 days.	
Enter Days <input type="text"/>	A. Antipsychotic
Enter Days <input type="text"/>	B. Antianxiety
Enter Days <input type="text"/>	C. Antidepressant
Enter Days <input type="text"/>	D. Hypnotic
Enter Days <input type="text"/>	E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days <input type="text"/>	F. Antibiotic
Enter Days <input type="text"/>	G. Diuretic
Enter Days <input type="text"/>	H. Opioid

Definitions

Adverse Consequence - An unpleasant symptom or event that is caused by or associated with a medication, impairment or decline in an individual's physical condition, mental, functional or psychosocial status. It may include various types of adverse drug reactions (ADR) and interactions (e.g., medication-medication, medication-food, and medication-disease).

Non-Pharmacological Intervention - Approaches that do not involve the use of medication to address a medical condition.

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

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

Sleep Hygiene- Practices, habits and environmental factors that promote and/or improve sleep patterns.

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

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

potential for adverse consequences.

Item Rationale

Health-related Quality of Life

- Medications are an integral part of the care provided to individuals. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.
- Individuals taking medications in these drug classes are at risk of side effects that can adversely affect health, safety, and quality of life.
- While assuring that only those medications required to treat the individual's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the individual's assessed condition.
- As part of all medication management, it is important to consider non-pharmacological approaches. Educating community caregivers and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications.

Planning for Care

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

Steps for Assessment

1. Review the individual's medical record or medication administration record, if available, for documentation that any of these medications were received by the individual during the 7-day look-back period.
2. Review documentation from other health care settings where the individual may have received any of these medications (e.g., valium given in the emergency room).
3. Ask the individual or caregiver what medications the individual has taken during the 7-day look-back period.

Coding Instructions

- **Check A, antipsychotic:** if antipsychotic medication was received by the individual at any time during the 7-day look-back period.
- **Check B, antianxiety:** if anxiolytic medication was received by the individual at any time during the 7-day look-back period.
- **Check C, antidepressant:** if antidepressant medication was received by the individual at any time during the 7-day look-back period.
- **Check D, hypnotic:** if hypnotic medication was received by the individual at any time during the 7-day look-back period.
- **Check E, anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin):** if anticoagulant medication was received by the individual at any time during the 7-day look-back period. Do not code antiplatelet medications such as aspirin /extended release, dipyridamole (Aggrenox), or clopidogrel (Plavix) here.
- **Check F, antibiotic:** if antibiotics were received by the individual at any time during the 7-day look-back period.
- **Check G, diuretic:** if diuretics were received by the individual at any time during the 7-day look-back period.
- **Check H, Opioid:** if opioids were received by the individual at any time during the 7-day look-back period.
- **Check Z, none of the above were received:** if none of the medications in Item N0410 were received during the 7-day look-back period (or since the Initial Assessment if less than 7 days).

Coding Tips and Special Populations

- Code medications according to a drug's pharmacological classification, not how it is used. For example, Oxazepam (Serax) may be used as a hypnotic, but it is classified as an antianxiety medication. It would be coded as an antianxiety medication.
- Include any of these medications given to the individual by any route (e.g., PO, IM, or IV) in any setting.
- Code a medication even if it was given only once during the look-back period.
- Count long-acting medications, such as fluphenazine deconoate (Prolixin) or haloperidol deconoate (Haldol), that are given every few weeks or monthly **only** if they are given during the 7-day look-back period.
- Combination medications should be coded in all categories that constitute the combination. For example, if the individual receives a single tablet that combines an antipsychotic and an antidepressant, then both antipsychotic and antidepressant should be coded.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not classified as hypnotic drugs.
- When individuals are having difficulty sleeping, caregivers should explore non-pharmacological interventions (e.g., sleep hygiene approaches that individualize the sleep and wake times to accommodate the person's wishes and prior customary routine) to try to improve sleep prior to initiating pharmacologic interventions. If individuals are currently on sleep-enhancing medications, caregivers can try non-pharmacologic interventions to help

reduce the need for these medications or eliminate them.

- Many psychoactive medications increase confusion, sedation, and falls. For those individuals who are already at risk for these conditions, a plan of care should be created to address these risks.
- Adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term “side effect” is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.
- Doses of psychopharmacologic drugs differ in acute and long-term treatment. Doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the individual’s function, well-being, safety, and quality of life. Duration of treatment should also be in accordance with pertinent literature, including clinical practice guidelines.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information, such as indications and precautions, dosage, monitoring, or adverse consequences.
- Prior to discontinuing a psychoactive drug, individuals may need a GDR or tapering to avoid withdrawal syndrome (e.g., selective serotonin reuptake inhibitors [SRIs], tricyclic antidepressants [TCAs]).
- Individuals who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances, duration of use, and stability of monitoring results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]). Multiple medication interactions exist with use of anticoagulants which may significantly increase PT/INR results to levels associated with life-threatening bleeding, or decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document an individual’s intake of herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the individual is currently taking.
- Opioid medications can be an effective intervention in an individual’s pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the individual’s pain should be conducted prior to initiation of an opioid medication and re-evaluation of the individual’s pain, side effects, and medication use and

plan should be ongoing.

Example

1. Mrs. P. received the following medications:
Haloperidol (Haldol) 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday. Lorazepam (Ativan) 1 mg PO QAM: Received every day. Temazepam (Restoril) 15 mg PO QHS PRN: Received at HS on Tuesday and Wednesday only.

Coding: The following **Medications** item (N0410), would be checked: **A, antipsychotic; B, antianxiety; and D, hypnotic.**

Rationale: Haloperidol is an antipsychotic drug, Lorazepam is an antianxiety drug, and Temazepam is a hypnotic drug.

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, programs, and procedures that the individual received during the specified time periods.

00100: Special Treatments, Procedures, and Programs (14-Day Look-back)

Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedures, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

Section O		Special Treatments, Procedures, and Programs
00100. Special Treatments, Procedures, and Programs		
Check all of the following treatments, procedures, and programs that were performed during the last 14 days		
		Check all that apply ↓
Cancer Treatments		
A. Chemotherapy		<input type="checkbox"/>
B. Radiation		<input type="checkbox"/>
Respiratory Treatments		
C. Oxygen therapy		<input type="checkbox"/>
D. Suctioning		<input type="checkbox"/>
E. Tracheostomy care		<input type="checkbox"/>
F. Invasive Mechanical Ventilator (ventilator or respirator)		<input type="checkbox"/>
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)		<input type="checkbox"/>
Other		
H. IV medications		<input type="checkbox"/>
I. Transfusions		<input type="checkbox"/>
J. Dialysis		<input type="checkbox"/>
K. Hospice care		<input type="checkbox"/>
L. Respite care		<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		<input type="checkbox"/>
N99. Psychiatric care		<input type="checkbox"/>
None of the Above		
Z. None of the above		<input type="checkbox"/>

Item Rationale

Health-related Quality of Life

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

Planning for Care

Reevaluation of special treatments the individual received or programs that the individual was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments or program.

Step for Assessment

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

Coding Instructions

Check all treatments, programs, and procedures received by the individual within the 14-day look-back period. **Check Z, None of the above.**

- **O0100A, Chemotherapy** ®

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, Megace (megestrol acetate) is classified in the **Physician's Desk Reference (PDR)** as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the individual is not receiving the Megace for chemotherapy purposes in this situation. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding this assessment. IV's, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), and O0100I (Transfusions).

Example: Ms. J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After her cancer treatment, Ms. J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

- **O0100B, Radiation** ®

Code intermittent radiation therapy, as well as, radiation administered via radiation implant in

this item.

- **O0100C, Oxygen therapy** ®

Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to an individual to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the individual places or removes his/her own oxygen mask, cannula.

- **O0100D, Suctioning** ®

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the individual performs his/her own tracheal and/or nasopharyngeal suctioning.

- **O0100E, Tracheostomy care** ®

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the individual performs his/her own tracheostomy care.

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

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensures adequate ventilation in the individual who is, or who may become, (such as during weaning attempts) **unable to support his or her own respiration** in this item. During invasive mechanical ventilation the individual's breathing is controlled by the ventilator. Individuals receiving closed-system ventilation include those individuals receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. An individual who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

Example: Mrs. J is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day, because of an irreversible neurological injury and inability to breathe on her own. O0100F should be checked, as Mrs. J is using an invasive mechanical ventilator because she is unable to initiate spontaneous breathing on her own and the ventilator is controlling her breathing.

- **O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP)**

Code any type of CPAP or BiPAP respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support his or her own spontaneous respiration** by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for

the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the individual places or removes his/her own BiPAP/CPAP mask/device.

Example: Mr. M has sleep apnea and requires a CPAP device to be worn when sleeping. The caregiver may set-up the water receptacle and humidifier element of the machine. Mr. M puts on the CPAP mask and starts the machine prior to falling asleep. O0100G should be checked as Mr. M is able to breathe on his own and wears the CPAP mask when he is sleeping to manage his sleep apnea.

- **O0100H, IV medications** ®

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here. To determine what products are considered medications or for more information consult the FDA website:

- The Orange Book, <http://www.accessdata.fda.gov/scripts/cder/ob/>
- The National Drug Code Directory, <http://www.fda.gov/drugs/informationondrugs/ucm142438.htm>

- **O0100I, Transfusions** ®

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

- **O0100J, Dialysis** ®

Code peritoneal or renal dialysis that occurs in the community setting (e.g., outpatient setting or in an individual's residence) in this item. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0500A (Parenteral/IV), O0100H (IV medications), and O0100I (transfusions). This item may be coded if the individual performs his/her own dialysis.

- **O0100K, Hospice care**

Code individuals identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related

conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

- **O0100L, Respite care**

Code only when the individual has utilized respite care for the purpose of providing relief to the individual's primary home-based caregiver(s) in this item. This item includes in-home and out-of-home respite.

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

Code only when the individual requires strict isolation or quarantine in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease, in an attempt to prevent spread of illness. Do not code this item if the individual only has a **history** of infectious disease (e.g., MRSA or C-Diff with no active symptoms). Do not code this item if the "isolation" primarily consists of body/fluid precautions, because these types of precautions apply to everyone. Transmission-Based Precautions must also be considered regarding the type and clinical presentation related to the specific communicable disease. The three types of transmission-based precautions are contact, droplet, and airborne. More information related to the types of transmission-based precautions can be found in the **2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings** <http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf>.

- **O0100N99, Psychiatric Care**

Psychiatric Care is therapy provided only by a licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a Masters degree and/or certification from the American Nurses Association. Psychiatric Technicians are not considered to be licensed mental health professionals and their services may not be counted in this item. If the State does not license a certain category of professionals working in your community program, you may not count the services of those unlicensed therapists in this item.

Code only if the individual has received services through a licensed mental health professional within the last 14 days.

- **O0100Z, None of the above**

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

O0400: Therapies

O0400. Therapies	
<p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Days <input type="text" value=""/></p>	<p>A. Speech-Language Pathology and Audiology Services</p> <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the individual individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy</p> <ol style="list-style-type: none"> 3A. Co-treatment minutes - record the total number of minutes therapy was administered to the individual in the last 7 days Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the last assessment) started <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/> Month Day Year Therapy end date - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/> Month Day Year
<p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Minutes <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></p> <p>Enter Number of Days <input type="text" value=""/></p>	<p>B. Occupational Therapy</p> <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the individual individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy</p> <ol style="list-style-type: none"> 3A. Co-treatment minutes - record the total number of minutes therapy was administered to the individual in the last 7 days Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the last assessment) started <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/> Month Day Year Therapy end date - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/> - <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/> Month Day Year

O0400 continued on next page

O0400. Therapies - Continued	
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/>	C. Occupational Therapy 1. Individual minutes - record the total number of minutes this therapy was administered to the individual individually in the last 7 days 2. Concurrent minutes - record the total number of minutes this therapy was administered to the individual concurrently with one other individual in the last 7 days 3. Group minutes - record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy 3A. Co-treatment minutes - record the total number of minutes therapy was administered to the individual in the last 7 days 4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days 5. Therapy start date - record the date the most recent therapy regimen (since the last assessment) started <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="text"/> - <input type="text"/> - <input type="text"/> Month Day Year </div> <div style="text-align: center;"> <input type="text"/> - <input type="text"/> - <input type="text"/> Month Day Year </div> </div> 6. Therapy end date - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="text"/> - <input type="text"/> - <input type="text"/> Month Day Year </div> <div style="text-align: center;"> <input type="text"/> - <input type="text"/> - <input type="text"/> Month Day Year </div> </div>
Enter Number of Minutes <input type="text"/> Enter Number of Days <input type="text"/>	D. Respiratory Therapy 1. Total minutes - record the total number of minutes this therapy was administered to the individual in the last 7 days If zero, → skip to O0400E, Psychological Therapy 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
Enter Number of Minutes <input type="text"/> Enter Number of Days <input type="text"/>	E. Psychological Therapy (by any licensed mental health professional) 1. Total minutes - record the total number of minutes this therapy was administered to the individual in the last 7 days If zero, → skip to O0400F, Recreational Therapy 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
Enter Number of Minutes <input type="text"/> Enter Number of Days <input type="text"/>	F. Recreational Therapy (includes recreational and music therapy) 1. Total minutes - record the total number of minutes this therapy was administered to the individual in the last 7 days If zero, → skip to O0420, Distinct Calendar Days of Therapy 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician or licensed practitioner (physician's assistant, nurse practitioner, and/or clinical nurse specialist), is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to individuals.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help individuals to attain or maintain their highest level of well-being and improve their quality of life.

Planning for Care

- Code only medically necessary therapies that occurred in the 7-day look-back period. All therapies listed in this section must be coded regardless of whether they occurred inside or outside the home, such as in a school or clinic setting and regardless of how the service was purchased.
- To be coded here, therapies must be:
 - (1) ordered by a physician or licensed practitioner based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan,
 - (2) performed by a qualified therapist (i.e. one who meets State credentialing requirements) with one exception; respiratory therapy must be coded here if provided by a trained nurse, or if it is a task delegated to a trained caregiver under the license of a trained nurse, NOTE: Nebulizer treatments administered by family members (or other individuals, non-licensed or not delegated to under the license of a nurse) are not coded in O0400D1; in this case nebulizer treatments should be entered in section S9, Medications, and may also be noted in S10, Comments.
 - (3) documented in the individual's medical record, and
 - (4) care planned and periodically evaluated to ensure that the individual receives needed therapies and that current treatment plans are effective.

Steps for Assessment

1. Review the individual's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes) if available, and consult with each of the qualified care providers to collect the information required for this item.

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes** ®—Enter the total number of minutes of therapy that was provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one individual at a time.
- **Concurrent minutes** ®—Enter the total number of minutes of therapy that was provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 individuals at the same time, when the individuals are performing two different activities.
- **Group minutes** ®—Enter the total number of minutes of therapy that was provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined as the treatment of 2 to 4 individuals who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.
 - **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the individual in co-treatment sessions in the last 7 days. Enter 0 if none were provided.”

- **Days ®**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more during the day. **Enter 0** if none was provided **or** if therapy was provided for less than 15 minutes on that day.
- **Therapy Start Date**—Record the date of the most recent therapy regimen (since the last assessment) started. Start dates are not affected by the 7-day look-back period.
- **Therapy End Date**—Record the date the most recent therapy regimen (since the last assessment) ended. Enter dashes if therapy is ongoing.

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none.
- **Days ®**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if none **or** if therapy was provided for less than 15 minutes in the day.

Coding Tips and Minutes of Therapy

- Includes only therapies that were provided when the individual is living/being cared for in the community setting (e.g., therapies provided at the individual’s residence, the school setting, a Day Activity and Health Services Program (DAHS) facility). Do **NOT** include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility.
- An exact therapy start date is not required. Ask the individual or caregiver when the therapy started, for example: 1)06-01-2009 can be entered if all the individual or caregiver can recall is the therapy started in the summer of 2009; 2)01-01-2008 can be entered if the individual or caregiver can only recall the year the therapy started.
- For individuals who receive therapy on an ongoing basis, enter the start date of the most recent therapy treatment plan. If for example: 1)the individual has been receiving physical therapy for the past year then has surgery and post-operatively the therapy changes, enter the start date of the new therapy plan; 2)the individual falls, the therapy changes and new therapy goals are established, enter the start date of the new therapy plan.
- The therapist’s time spent on documentation or on initial evaluation is not included.
- The therapist’s time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- The individual’s treatment time starts when he or she begins the first treatment activity or task and ends when he or she finishes with the last apparatus or intervention/task and the treatment is ended, as long as the services were not interrupted (for example, by a bathroom break or a nontherapeutic rest).
- The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular individual, is the set-up time and may be included in the count of minutes of therapy delivered to the individual.

- Include only skilled therapy services. Skilled therapy services must meet the following conditions:
 - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the community setting that is approved by the physician after any needed consultation with the qualified therapist;
 - the services must be of a level of complexity and sophistication, or the condition of the individual must be of a nature that requires the judgment, knowledge, and skills of a therapist;
 - the services must be provided with the expectation, based on the assessment made by the physician of the individual's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;
 - the services must be considered under accepted standards of medical practice to be specific and effective treatment for the individual's condition; and,
 - the services must be reasonable and necessary for the treatment of the individual's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.
- In the community setting concurrent and group therapies rarely occur.
- Recreational therapy is not a skilled service according to the Social Security Act. However, for purposes of the Medical Necessity/Level of Care Assessment (MN/LOC), providers should record services for recreational therapy (Item O0400F) when the following criteria are met:
 - the physician orders recreational therapy that provides therapeutic stimulation beyond the general activity in the community setting;
 - the physician's order includes a statement of frequency, duration, and scope of treatment;
 - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by a therapeutic recreation specialist;
 - the services are required and provided by a state licensed or nationally certified therapeutic recreation specialist or therapeutic recreation assistant, who is under the direction of a therapeutic recreation specialist; and
 - the services must be reasonable and necessary for the individual's condition.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the home health care organization only if he or she is under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MN/LOC.
- Record only the actual minutes of therapy. The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MN/LOC requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs, if available, may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MN/LOC assessment.

Non-Skilled Services

- Once the licensed therapist has designed a maintenance program and discharged the individual from rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in Item O0400A, B, or C (Therapies). The services may be reported on the MN/LOC assessment in Item O0500 (Restorative Nursing Programs), provided the requirements for restorative nursing programs are met.
- Services provided by aides are **not** skilled services.

Co-treatment

When two clinicians, each from a different discipline, treat one individual at the same time, the clinicians must split the time between the two disciplines as they deem appropriate. They may not each count the treatment session in full, and the split times when added may not exceed the actual total amount of the treatment session.

Therapy Aides and Students

Therapy Aides

Aides cannot provide skilled services. Only the time an aide spends on set-up for skilled services may be coded on the MN/LOC (e.g., set up the treatment area for wound therapy).

Therapy Students

- Medicare Part A—Therapy students must be in line-of-sight supervision of the professional therapist (**Federal Register**, July 30, 1999). The time spent by the therapist providing skilled services by supervising the student who participates by following the therapist's direction under line-of-sight supervision may be coded on the MN/LOC.
- Medicare Part B—The following criteria must be met in order for services provided by a student to be coded on the MN/LOC. The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
 - The practitioner is not engaged in treating another patient or doing other tasks at the same time.
 - The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician's service, not for the student's services.)
 - Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist.

Modes of Therapy

An individual may receive therapy via different modes during the same day or even treatment session. The therapist and assistant must determine which mode(s) of therapy and the amount of time the individual receives for each mode.

Individual Therapy

The treatment of one individual at a time. The individual is receiving the therapist's or the assistant's full attention. Treatment of an individual individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count. For example, the speech-language pathologist treats the individual individually during breakfast for 8 minutes and again at lunch for 13 minutes. The total of individual time for this day would be 21 minutes.

Concurrent Therapy

- **Medicare Part A**

The treatment of 2 individuals at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

- **Medicare Part B**

The treatment of two or more individuals at the same time is documented as group treatment, regardless of whether those individuals are doing the same or different activities.

Group Therapy

- **Medicare Part A**

The treatment of 2 to 4 individuals, regardless of payer source, who are performing similar activities, and are supervised, by a therapist or assistant who is not supervising any other individuals.

- **Medicare Part B**

The treatment of 2 or more individuals simultaneously who may or may not be performing the same activity.

Example

Following a stay in a rehabilitation facility for a hip fracture, Mrs. F has now returned home. A licensed physical therapist from a local home health agency is providing skilled therapy for 30 minutes, twice per week. Code 60 for this service in section O0400C1. In addition, the therapist has instructed Mrs. F's caregiver in a home program to increase Mrs. F's walking skills/distance. Code the home program administered by the caregiver in section O0500F.

O0420. Distinct Calendar Days of Therapy	
Enter Number of Days <input type="text"/>	Record the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Item Rationale

To record the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Coding Instructions:

Enter the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days. If an individual receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

- Example 1: Mrs. T. received 60 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mrs. T also received 45 minutes of occupational therapy on Monday, Tuesday and Friday during the 7-day look-back period. Given the therapy services received by Mrs. T during the 7-day look-back period, item **O0420 would be coded as 4** because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Tuesday, Wednesday, and Friday).
- Example 2: Mr. F. received 120 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mr. F also received 90 minutes of occupational therapy on Monday, Wednesday and Friday during the 7-day look-back period. Finally, Mr. F received 60 minutes of speech-language pathology services on Monday and Friday during the 7-day look-back period. Given the therapy services received by Mr. F during the 7-day look-back period, item **O0420 would be coded as 3** because therapy services were provided for at least 15 minutes on 3 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday)."

O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs	
Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prostheses care
<input type="checkbox"/>	J. Communication

Item Rationale

Health-related Quality of Life

- Maintaining independence in activities of daily living and mobility is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers/injuries.

Planning for Care

- Restorative program refers to nursing interventions that promote the individual's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
- A individual may be started on a restorative program when he or she has restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise. Generally, restorative nursing programs are initiated when an individual is discharged from formalized physical, occupational, or speech rehabilitation therapy. Persons qualified to perform rehabilitation/restorative care include, but are not limited to: family members, caregivers and attendants specifically trained in these techniques/practices. This section does not include procedures carried out by the qualified therapist as identified in section O0400.

Steps for Assessment

1. Review the restorative nursing program notes and/or flow sheets in the medical record if available.
2. For the 7-day look-back period, enter the number of days on which the technique, procedure, or activity was received and/or practiced for a total of at least 15 minutes during the 24-hour period.
3. The following criteria for restorative care must be met:
 - Measurable objectives and interventions must be documented in the plan of care. If a restorative nursing program is in place when a plan of care is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the record.
 - Evidence of periodic evaluation by the licensed nurse must be documented. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
 - Nursing assistants/aides must be skilled in the techniques that promote individual involvement in the activity.
 - A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program.
 - Restorative nursing does not require a physician's order.

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** Item (O0400A), **Occupational Therapy** item (O0400B), and **Physical Therapy** (O0400C).
- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. For example, to check **Technique—Range of Motion [Passive]** item (O0500A), 15 or more minutes of passive range of motion (PROM) must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift). However, 15-minute time increments cannot be obtained by combining 5 minutes of **Technique—Range of Motion [Passive]** item (O0500A), 5 minutes of **Technique—Range of Motion [Active]** item (O0500B), and 5 minutes of **Splint or Brace Assistance** item (O0500C), over 2 days in the last 7 days.
- Review for each activity throughout the 24-hour period. **Enter 0**, if none.

Technique

Activities provided by caregivers trained in restorative nursing techniques.

- **O0500A, Range of Motion (Passive) ®**

Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be planned, scheduled, and documented in the medical record.

- **O0500B, Range of Motion (Active) ®**

Code exercises performed by the individual, with cueing, supervision, or physical assist by caregivers that are planned, scheduled, and documented in the medical record. Include active ROM and active-assisted ROM.

- **O0500C, Splint or Brace Assistance ®**

Code provision of (1) verbal and physical guidance and direction that teaches the individual how to apply, manipulate, and care for a brace or splint, or (2) a scheduled program of applying and removing a splint or brace. These sessions are planned, scheduled, and documented in the medical record.

Training and Skill Practice

Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any caregivers under the supervision of a licensed nurse.

- **O0500D, Bed Mobility ®**

Code activities provided to improve or maintain the individual's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed.

- **O0500E, Transfer ®**

Code activities provided to improve or maintain the individual's self-performance in moving between surfaces or planes either with or without assistive devices.

- **O0500F, Walking ®**

Code activities provided to improve or maintain the individual's self-performance in walking, with or without assistive devices.

- **O0500G, Dressing and/or Grooming ®**

Code activities provided to improve or maintain the individual's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

- **O0500H, Eating and/or Swallowing** ®

Code activities provided to improve or maintain the individual's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the individual's ability to ingest nutrition and hydration by mouth.

- **O0500I, Amputation/ Protheses Care** ®

Code activities provided to improve or maintain the individual's self-performance in putting on and removing prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item.

- **O0500J, Communication** ®

Code activities provided to improve or maintain the individual's self-performance in functional communication skills or assisting the individual in using residual communication skills and adaptive devices.

Coding Tips

- For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the individual's available range of motion. The individual provides no assistance.
- For range of motion (active): any participation by the individual in the ROM activity should be coded here.
- For both active and passive range of motion: movement by an individual that is incidental to dressing, bathing, etc., does not count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by caregivers specifically trained in the procedures.
- For splint or brace assistance: assess the individual's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices as nursing restorative care is coded when the following criteria are met: (1) ordered by a physician, (2) caregivers have been trained in technique (e.g., properly aligning individual's limb in device, adjusting available range of motion), and (3) monitoring of the device. The caregiver should document the application of the device and the effects on the individual. Do **not** include the time the individual is receiving treatment in the device. Include only the actual time caregivers were engaged in applying and monitoring the device.
- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Grooming programs, including programs to help individuals learn to apply make-up, may be considered restorative nursing programs. These grooming programs would need to have documented goals, objectives, and documentation of progress in order to be coded in this section.

Example

1. Mrs. D. is receiving training and skill practice in walking using a quad cane. Together, Mrs. D. and her caregiver have set progressive walking distance goals. The caregiver has received instruction on how to provide Mrs. D. with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to walk with her quad cane. Each teaching and practice episode for walking takes approximately 15 minutes.

Coding: Walking item (O0500F), would be **coded 7**.

Rationale: Because this was the number of days that practice training for walking was provided.

O0600: Physician Examinations ® (14-Day Look-back)

O0600. Physician Examinations	
Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the individual?

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Frequency of physician examinations can be an indication of medical complexity and stability of the individual's health status.

Step for Assessment

1. Review the physician progress notes, if available, for evidence of examinations by the physician/practitioner. If notes are not available, ask the individual or caregiver if an examination took place within the 14-day look-back period.

Coding Instructions

- Record the **number of days** that a physician examined the individual in the look-back period.

Coding Tips

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician.
- Examination (partial or full) can occur in the community setting or in the physician's office.
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If an individual is evaluated by a physician (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 individual, monitoring the individual for response to the treatment, or adjusting the treatment as a result of the examination.
- The licensed psychological therapy by a Psychologist (PhD) should be recorded in **O0400E, Psychological Therapy**.
- Does not include visits made by Medicine Men.

O0700: Physician Orders ® (14-Day Look-back)

O0700. Physician Orders	
Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the individual's orders?

Item Rationale

Health-related Quality of Life

- Health status that requires frequent physician (or authorized assistant or practitioner) order changes can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- Frequency of physician (or authorized assistant or practitioner) order changes can be an indication of medical complexity and stability of the individual's health status.

Steps for Assessment

1. Review the physician order sheets in the medical record, if available.
2. Determine the number of days during the 14-day look-back period that a physician (or authorized assistant or practitioner) changed the individual's orders.

Coding Instruction

- Enter the **number of days** during the 14-day look-back period in which a physician (or authorized assistant or practitioner) changed the individual's orders.

Coding Tips

- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- When an as needed (PRN) order was already on file, the potential need for the service had already been identified. Notification of the physician (or authorized assistant or practitioner) that the PRN order was activated does **not** constitute a new or changed order and may **not** be counted when coding this item.
- If an individual has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MN/LOC must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- Orders written to increase the individual's RUG classification are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.

SECTION P: RESTRAINTS AND ALARMS

Intent: The intent of this section is to record the frequency that the individual was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.

Prior to using any restraint, the caregiver should assess the individual to properly identify the individual's needs and the medical symptom(s) that the restraint is being employed to address. If a restraint is needed to treat the individual's medical symptom, the caregiver is responsible for assessing the appropriateness of that restraint. When the decision is made to use a restraint, DADS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. The use of restraints should be the exception, not the rule.

P0100: Physical Restraints

P0100. Physical Restraints	
Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the individual's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	Used in Bed
	<input type="checkbox"/> A. Bed rail
	<input type="checkbox"/> B. Trunk restraint
	<input type="checkbox"/> C. Limb restraint
	<input type="checkbox"/> D. Other
	Used in Chair or Out of Bed
	<input type="checkbox"/> E. Trunk restraint
	<input type="checkbox"/> F. Limb restraint
	<input type="checkbox"/> G. Chair prevents rising
<input type="checkbox"/> H. Other	

Definitions

Remove easily - means that the manual method, device, material, or equipment can be removed intentionally by the individual in the same manner as it was applied by the caregiver (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the individual's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).

Freedom of movement - means any change in place or position for the body or any part of the body that the person is physically able to control or access.

Item Rationale

Health-related Quality of Life

- Growing evidence supports that physical restraints have a limited role in medical care. Restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers/injuries.
- Individuals who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In many cases, the risk of using the device may be greater than the risk of not using the device.
- The risk of restraint-related injury and death is significant.

Planning for Care

- When the use of restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues.
- When the interdisciplinary team determines that the use of restraints is the appropriate course of action, the least restrictive device that will meet the individual's needs should be selected.
- Planning for care should focus on preventing the adverse effects of restraint use.

Steps for Assessment

1. Review the individual's medical record, if available, to determine if physical restraints were used during the 7-day look-back period.
2. Interview the caregiver to determine if physical restraints were used during the 7-day look-back period.
3. Consult the caregiver to determine the individual's cognitive and physical status/limitations.
4. Considering the physical restraint definition as well as the clarifications listed below, observe the individual to determine the effect the restraint has on the individual's normal function. Do not focus on the type of device, intent, or reason behind the use of the device.
5. Evaluate whether the individual can easily and voluntarily remove the device, material, or equipment. If the individual cannot easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the

individual's access to his or her own body.

6. Determine if the device, material, or equipment meets the definition of a physical restraint as clarified below. Remember, the decision about coding any device, material, equipment, or physical or manual method as a restraint depends on the effect the device has on the individual. This can only be determined on a case-by-case basis by individually assessing each and every device (whether or not it is listed specifically on the MN/LOC) and its effect on the individual.
7. Any device, material, or equipment that meets the definition of a physical restraint should have a plan of care and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

Coding Instructions

Identify all restraints that were used at any time (day or night) during the 7-day look-back period.

After determining whether or not a device listed in (P0100) is a restraint and was used during the 7-day look-back period, code the frequency of use:

- **Code 0, not used:** if the device was not used during the 7-day look-back **or** it was used but did not meet the definition.
- **Code 1, used less than daily:** if the device met the definition and was used less than daily.
- **Code 2, used daily:** if the device met the definition and was used on a daily basis during the look-back period.

Coding Tips and Special Populations

- Any device that does not fit into the listed categories but that meets the definition of a restraint and has not been excluded from this section should be coded in items P0100D or P0100H, Other. These devices should be included in the plan of care and monitored.
- In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the purpose or intent of its use. It is possible for a device to improve the individual's mobility and also have the effect of restraining him or her.
- Exclude from this section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).
- Bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems.
- Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meets the definition of a physical restraint even though they may improve the individual's mobility in bed, the assessor must code their use as a restraint at P0100A.
 - Bed rails used with individuals who are immobile. If the individual is immobile and cannot voluntarily get out of bed because of a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do

- not meet the definition of a restraint.
- For individuals who have no voluntary movement, the caregiver needs to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some individuals have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, individual weight, and gravity's effects may lead to the individual's body shifting toward the edge of the bed. When bed rails are used in these cases, the individual could be at risk for entrapment. For this type of individual, clinical evaluation of alternatives (e.g., a concave mattress to keep the individual from going over the edge of the bed), coupled with frequent monitoring of the individual's position, should be considered. While the bed rails may not constitute a restraint, they may affect the individual's quality of life and create an accident hazard.
 - Trunk restraints include any device or equipment or material that the individual cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair.
 - Limb restraints include any device or equipment or material that the individual cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg). Included in this category are mittens.
 - Trunk or limb restraints, if used in both bed and chair, should be marked in both sections.
 - Chairs that prevent rising include any type of chair with a locked lap board, that places the individual in a recumbent position that restricts rising, or a chair that is soft and low to the floor. Included here are chairs that have a cushion placed in the seat that prohibit the individual from rising.
 - For individuals who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising.
 - Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a restraint. These types of walkers are only classified as a restraint if the individual cannot exit the gate. When deemed a restraint, these walkers should be coded at P0100G–Chair Prevents Rising.
 - Geriatric chairs used for individuals who are immobile. For individuals who have no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint.
 - For individuals who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint, and should not be coded at P0100H–Other.
 - Restraints used in emergency situations. If the individual needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed, unless the individual or legal representative has previously made a valid refusal of the treatment in question. The use of physical restraints in this instance should be limited to preventing the individual from interfering with life-sustaining procedures only and not for routine care.
 - An individual who is injuring himself/herself or is threatening physical harm to others may be restrained in an emergency to safeguard the individual and others. An individual whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of restraints, as long as those restraints are used as a last resort to protect the safety of the individual or others and use is limited to the immediate episode.

Additional Information

- Restraint reduction/elimination. For individuals whose plan of care indicates the need for restraints, a gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening activities) should be employed.
- Restraints as a fall prevention approach. Although restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually **decrease** the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
- Request for restraints. As with other medical treatments, such as the use of prescription drugs, an individual, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary.
- Medical symptoms/diagnoses - are defined as an indication or characteristic of a physical or psychological condition. Objective findings derived from clinical evaluation of the individual's medical diagnoses and subjective symptoms should be considered when determining the presence of medical symptom(s) that might support restraint use. The individual's subjective symptoms may not be used as the sole basis for using a restraint. In addition, the individual's medical symptoms/diagnoses should not be viewed in isolation; rather, the medical symptoms identified should become the context in which to determine the most appropriate method of treatment related to the individual's condition, circumstances, and environment, and not a way to justify restraint use.
- The identification of medical symptoms should assist the caregiver in determining if the specific medical symptom can be improved or addressed by using other, less restrictive interventions. The caregiver should perform all due diligence and document this process to ensure that they have exhausted alternative treatments and less restrictive measures before a restraint is employed to treat the medical symptom, protect the individual's safety, help the individual attain or maintain his or her highest level of physical or psychological well-being and support the individual's goals, wishes, independence, and self-direction.
- Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom. Restraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent an individual from injuring himself/herself or others and/or to prevent the individual from interfering with life-sustaining treatment when no other less restrictive or less risky interventions exist.
- A clear link must exist between the restraint use and how it benefits the individual by addressing the specific medical symptom.

P0200: Alarms

P0200. Alarms	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. Bed alarm
	<input type="checkbox"/> B. Chair alarm
	<input type="checkbox"/> C. Floor mat alarm
	<input type="checkbox"/> D. Motion Sensor alarm
	<input type="checkbox"/> E. Wander/elopement alarm
	<input type="checkbox"/> F. Other alarm

Item Rationale

Health-related Quality of Life

- An alarm is any physical or electronic device that monitors individual movement and alerts the caregiver, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the individual's clothing, motion sensors, door alarms, or elopement/wandering devices.
- While often used as an intervention in an individual's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
- The use of an alarm as part of an individual's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
- Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

Planning for Care

- Individualized, person-centered care planning surrounding the individual's use of an alarm is important to the individual's overall well-being.
- When the use of an alarm is considered as an intervention in the individual's safety strategy, use must be based on the assessment of the individual and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions.
- There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the individual's freedom of movement and may not be easily removed by the individual.

Steps for Assessment

1. Review the individual's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
2. Consult the caregiver to determine the individual's cognitive and physical status/limitations.
3. Evaluate whether the alarm affects the individual's freedom of movement when the alarm/device is in place. For example, does the individual avoid standing up or repositioning himself/herself due to fear of setting off the alarm?

Coding Instructions

An alarm is any physical or electronic device that monitors an individual's movement and alerts when movement is detected.

Enter Codes in Boxes:

- **Code 0, not used:** if the device was not used during the 7-day look-back **or** it was used but did not meet the definition.
- **Code 1, used less than daily:** if the device met the definition and was used less than daily.
- **Code 2, used daily:** if the device met the definition and was used on a daily basis during the look-back period.

Coding Tips and Special Populations

- **Bed alarm** includes devices such as a sensor pad placed on the bed or a device that clips to the individual's clothing.
- **Chair alarm** includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the individual's clothing.
- **Floor mat alarm** includes devices such as a sensor pad placed on the floor beside the bed.
- **Motion sensor alarm** includes infrared beam motion detectors.
 - **Wander/elopement alarm** includes devices such as bracelets, pins/buttons worn on the individual's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the individual that alert the caregiver when the individual nears or exits an area or building. This includes devices that are attached to the individual's assistive device (e.g., walker, wheelchair, cane) or other belongings.
 - **Other alarm** includes devices such as alarms on the individual's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.
- Code any type of alarm, audible or inaudible, used during the look-back period in this section.
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.
 - Motion sensors and wrist sensors worn by the individual to track the individual's sleep patterns should not be coded in this section.
 - Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the individual appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the

degree possible.

- While wander, door, or building alarms can help monitor an individual's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision.
- Bracelets or devices worn or attached to the individual and/or his or her belongings that signal a door to lock when the individual approaches should be coded in P0200F Other alarm, whether or not the device activates a sound.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: The items in this section are intended to record the participation and expectations of the individual, family members, or significant other(s) in the assessment, and to understand the individual's overall goals.

Q0100: Participation in Assessment

Q0100. Participation in Assessment	
Enter Code <input type="text"/>	A. Individual participated in assessment 0. No 1. Yes
Enter Code <input type="text"/>	B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other available
Enter Code <input type="text"/>	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative available

Item Rationale

Health-related Quality of Life

Individuals who actively participate in the assessment process and in developing the care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- The plan of care should be person-centered and person-driven.
- Many individuals want their caregiver, family or significant other(s) to be involved in the assessment process.
- When the individual is unable to participate in the assessment process, caregivers, family or significant others can provide valuable information about the individual's needs, goals, and priorities.

Steps for Assessment

1. Follow coding instructions.

Coding Instructions for Q0100A, Individual Participated in Assessment

Record the participation of the individual in the assessment process.

- **Code 0, no:** if the individual did not actively participate in the assessment process.

- **Code 1, yes:** if the individual actively and meaningfully participated in the assessment process.

Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment

Record the participation of the family or significant other in the assessment process.

- **Code 0, no:** if the family or significant other did not participate in the assessment process.
- **Code 1, yes:** if the family or significant other(s) did participate in the assessment process.
- **Code 9, no family or significant other available:** if there is no family or significant other or none is available.

Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment

Record the participation of the guardian or legally authorized representative in the assessment process.

- **Code 0, no:** if guardian or legally authorized representative did not participate in the assessment process.
- **Code 1, yes:** if guardian or legally authorized representative did participate in the assessment process.
- **Code 9, no guardian or legally authorized representative available:** if there is no guardian or legally authorized representative or none is available.

Q0300: Individual’s Overall Expectation

Complete only on Initial Assessment.

Q0300. Individual’s Overall Expectation	
Complete only if A0310A = 01	
Enter Code <input type="text"/>	A. Select one for individual’s overall goal established during assessment process 1. Expects to be discharged to the home (i.e. currently in ALF) 2. Expects to remain in the home 3. Expects to be transferred to a facility/institution 9. Unknown or uncertain
Enter Code <input type="text"/>	B. Indicate information source for Q0300A 1. Individual 2. If not individual, then family or significant other 3. If not individual, family, or significant other, then guardian or legally authorized representative 9. Unknown or uncertain

Item Rationale

This item identifies the individual’s general expectations and goals for future living arrangements.

Health-related Quality of Life

- Unless the individual’s goals for care are understood, the individual’s needs, goals, and priorities are not likely to be met.

Planning for Care

- The individual's goals should be the basis for the plan of care.

Steps for Assessment

1. Ask the individual about his or her overall expectations to be sure that he or she has participated in the assessment process.
2. Ask the individual to consider his or her current clinical status, expectations regarding improvement or worsening, and social supports.
3. Because of a temporary (e.g., delirium) or permanent (e.g., profound dementia) condition, some individuals may be unable to provide a clear response. If the individual is unable to communicate his or her preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.
4. If goals have not already been stated directly by the individual, ask the individual directly about what his or her expectation is regarding future living arrangements
5. The individual's goals—as perceived by the family, significant other, guardian, or legally authorized representative—should be recorded here only if the individual is unable to discuss his or her goals.
6. Encourage the involvement of family or significant others in the discussion, if the individual consents. Family, significant others, or, if necessary, the guardian or legally authorized representative can be involved if the individual is uncertain about his or her goals. The response selected must reflect the individual's perspective if he or she is able to express it.

Coding Instructions for Q0300A, Individual's Overall Goals Established during Assessment Process

Record the individual's expectations as expressed by her or him. It is important to document their expectations.

- **Code 1, expects to be discharged to the home (i.e. currently in ALF)**
- **Code 2, expects to remain in the home.**
- **Code 3, expects to be transferred to a facility/institution.**
- **Code 9, unknown or uncertain:** if the individual is uncertain or is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative are not available to participate in the discussion.

Coding Tips

- This item is person-centered and focuses on exploring the individual's expectations; not whether or not others consider them to be realistic.
- Avoid trying to guess what the individual might identify as a goal or to judge the individual's goal. Do not infer based on a specific advance care order, such as “do not resuscitate”

(DNR).

Coding Instructions for Q0300B, Indicate Information Source for Q0300A

- **Code 1, individual:** if the individual is the source for completing this item.
- **Code 2, if not individual, then family or significant other:** if the individual is unable to respond and family member or significant other is the source for completing this item.
- **Code 3, if individual, family or significant other, then guardian or legally authorized representative:** if the guardian or legally authorized representative is the source for completing this item because the individual is unable to respond and family member or significant other is not available to respond.
- **Code 9, unknown or uncertain (none of the above):** if the individual cannot respond and the family or significant other, or guardian or legally authorized representative cannot be contacted or is unable to respond.

Example

1. Mr. W. is a 73-year-old man who has severe heart failure and renal dysfunction. He also has a new diagnosis of metastatic colorectal cancer. He receives nursing and attendant services through the community program. He indicates that he is “strongly optimistic” about his future and only wants to think “positive thoughts” about what is going to happen and needs to believe that his health will improve and that he will be able to remain in his home.

Coding: Q0300A would be coded as **2, expects to remain in the home.**

Rationale: Mr. W has a clear goal to get well, even if this is unlikely based on medical diagnosis and current medical problems. This item should be coded based on the individual’s expressed goals.

SECTION Z: ASSESSMENT ADMINISTRATION

Intent: The intent of this section is to provide the signature of the RN completing the assessment.

Z0500: Signature of RN Completing Assessment

Z0500. Signature of RN Completing Assessment													
A. Signature	B. Date Assessment Completed:												
	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="2">Year</td></tr></table>							Month		Day		Year	
Month		Day		Year									

Item Rationale

Regulations require the RN to sign and thereby certify that the assessment is accurate and complete.

Steps for Assessment

1. Verify that all items on this assessment are complete.

Coding Instructions

- For Z0500B, use the actual date that the assessment was completed. If for some reason the assessment cannot be signed by the RN on the date it is completed, the RN should use the date that it is signed.

Example

1. A nurse assessor completes the face to face assessment on March 15, 2015. She does not receive all documentation required to complete the assessment (e.g., the physician's signature, information from the physical therapist, etc.) until March 23, 2015. The nurse assessor should enter March 23, 2015 in field Z0500B.

Section LTC Medicaid Information

S1. Medicaid Information

S1a. Medicaid Client Indicator

- This field will be auto-populated.

S1b. Individual Address

Required

- Enter the street address where the individual is presently living.
- Individual's Address is used for mailing Medical Necessity (MN) letters.

S1c. City

Required

- Enter the city where the individual is presently living.
- If a city has a hyphen in the city name, replace the hyphen with a space.
- If a city has an apostrophe in the city name, enter the city name without the apostrophe.

S1d. State

Required

- Enter the state where the individual is presently living.

S1e. Zip Code

Required

- Enter the zip code where the individual is presently living.

S1f. Phone

Optional

- Enter the contact phone number for the individual if known.
- If individual does not have a contact phone number, enter 000-000-0000.

S2. Claims Processing Information

S2a. DADS Vendor/Site ID Number

- This field will be auto populated based on the user's logon security credentials.
- This field is not correctable on the TMHP LTC Online Portal.

S2b. Provider Number

- This field is not correctable on the TMHP LTC Online Portal.
- If a National Provider Identifier (NPI) has more than one provider number associated, be sure the correct provider number is selected from the drop-down box.

S2c. Service Group

Required field – May be prepopulated, if not, choose from the drop down menu

- 11. PACE
- 18. MDCP
- 19. SPW
- 23. CFC

S2d. NPI Number

- Enter your NPI number.
- DADS Regional Nurses will enter their Atypical (API) number. Atypical numbers will usually consist of a “D” and the contract number.
- This field cannot be corrected once an assessment has been submitted.

S2e. Region

Choose the provider’s region from the list provided.

- 01 – Lubbock
- 02 – Abilene
- 03 – Grand Prairie
- 04 – Tyler
- 05 – Beaumont
- 06 – Houston
- 07 – Austin
- 08 – San Antonio
- 09 – Midland / Odessa
- 10 – El Paso
- 11 – Edinburg

S2f. Purpose Code

- Purpose Code is auto-populated when a Utilization Review Assessment is submitted. For Initial, Annual and SCSA assessments, this field is not available for data entry.
- This field is not able to be modified.
- This field cannot be corrected once an assessment has been submitted.

S2g. HHA License

- The field is required.
- If you work for a Home Health Agency (HHA), enter the Home Health Agency License number.
- HHA License # must be up to 7 numeric digits.
- If you do not work for a Home Health Agency (HHA), or you are an MDCP nurse completing the MN/LOC, enter all zeros.

S2h. HHA License # Expiration Date

- Enter the license expiration date of the Home Health Agency License number.
- License expiration date is required.
- HHA License # Expiration Date must be in mm/dd/yyyy format.

S3. Primary Diagnosis

S3a. Primary Diagnosis ICD Code

- Enter a valid ICD code for the individual's primary diagnosis. This diagnosis should be the one that most significantly contributes to the individual's need for the services of a licensed nurse.

S3b. Primary Diagnosis ICD Description

- Click the magnifying glass and the description will be auto populated based on the primary diagnosis ICD code.

S4. For DADS use only

S4a. MN

S4b. RUG

S4c. Effective Date

S4d. Expiration Date

S4e. County

S4f. DADS RN Signature

S4g. Signature Date

S5. Licenses

Certification: To the best of my knowledge, I certify to the accuracy and completeness of this information.

S5a. HHA RN Last Name

Required if Service Group = 3.

- Enter the last name of the RN completing the assessment.

S5b. HHA RN License #

Required if Service Group = 3.

- Enter the license number of the RN.
- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure RUG training requirements have been met.

S5c HHA RN License State

Required if Service Group = 3.

- Enter the state in which the RN is licensed.

S5d DADS RN Last Name

Required if Service Group = 18 OR Purpose code = 1 (UR)

Enter the last name of the RN completing the assessment.

S5e DADS RN License #

Required if Service Group = 18 OR Purpose code = 1 (UR)

Enter the license number of the RN.

- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure RUG training requirements have been met.

S5f DADS RN License State

Required if Service Group = 18 OR Purpose code = 1 (UR)

Enter the state in which the RN is licensed.

S5g DADS RN Signature Date

Required if Service Group = 18 OR Purpose code = 1 (UR)

Enter the date the DADS RN signed the assessment as being complete.

DADS RN Signature

- DADS Nurse must sign assessment as being complete.

S5h PACE RN Last Name

Required if Service Group = 11.

- Enter the last name of the RN completing the assessment.

S5i PACE RN License #

Required if Service Group = 11

- Enter the license number of the RN.
- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure RUG training requirements have been met.

S5j PACE RN License State

Required if Service Group = 11.

- Enter the state in which the RN is licensed.

S5k HMO RN Last Name

Required if Service Group = 19.

- Enter the last name of the RN completing the assessment.

S5l HMO RN License

Required if Service Group = 19.

- Enter the license number of the RN.
- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state's nursing board.
- This number is validated to ensure RUG training requirements have been met.

S5m HMO RN License State

Required if Service Group = 19.

- Enter the state in which the RN is licensed.

S6. Additional MN Information

S6a. Tracheostomy Care

This is a required field only available for data entry if O0100E, Tracheostomy care, is checked AND the individual is less than 22 years of age.

- Enter the number corresponding to the appropriate response.
 - 1 = Less than once a week
 - 2 = 1 to 6 times a week
 - 3 = Once a day
 - 4 = Twice a day
 - 5 = 3 – 11 times a day
 - 6 = Every 2 hours
 - 7 = Hourly / continuous

S6b. Ventilator / Respirator

This is a required field only available for data entry if O0100F, ventilator or respirator, is checked. Do not include BiPAP/CPAP.

- Enter the number corresponding to the appropriate response.
 - 1 = Less than once a week
 - 2 = 1 to 6 times a week
 - 3 = Once a day
 - 4 = Twice a day
 - 5 = 3 – 11 times a day
 - 6 = 6 – 23 hours
 - 7 = 24-hour continuous

S6c. Number of hospitalizations in the last 90 days

(90-Day Look-back)

This is a required field.

- Record the number of times the individual was admitted to hospital with an overnight stay in the last 90 days (or since last assessment if less than 90 days). Enter 0 (zero) if no hospital admissions.
- Valid range includes 0 – 90.

S6d. Number of emergency room visits in the last 90 days
(90-Day Look-back)

This is a required field.

- Record the number of times the individual visited the Emergency Room (ER) without an overnight stay in the last 90 days (or since last assessment if less than 90 days). Enter 0 (zero) if no ER visits.
- Valid range includes 0 – 90.

S6e. Oxygen Therapy

This is a required field only available for data entry if O0100C, Oxygen therapy, is checked.

- Enter the number corresponding to the appropriate response.
 - 1 = Less than once a week
 - 2 = 1 to 6 times a week
 - 3 = Once a day
 - 4 = Twice a day
 - 5 = 3 – 11 times a day
 - 6 = 6 – 23 hours
 - 7 = 24-hour continuous

S6f. Special Ports/Central Lines/PICC

This is an optional field.

- Use this field to indicate if the individual has any type of implantable access system or central venous catheter (CVC). This includes epidural, intrathecal or venous access or Peripherally Inserted Central Catheter (PICC) devices. This does NOT include hemodialysis or peritoneal dialysis access devices.
- Enter the corresponding value to the most appropriate response:
 - N = none present
 - Y = 1 or more implantable access system or CVC
 - U = unknown

S6g. At what developmental level is the individual functioning?

Field is correctable.

This is a required field for all assessments for individuals under age 21 based on birth date minus date of submission (TMHP Received date). Not available for data entry if the individual is 21 or older.

- Responses included in drop down are:
 1. < 1 Infant
 2. 1 – 2 Toddler
 3. 3 – 5 Pre-School
 4. 6 – 10 School age
 5. 11 – 15 Young Adolescence
 6. 16 – 20 Older Adolescence

‘ – ‘ Unknown or unable to assess choose the dash.

S6h. Enter the number of times this individual has fallen in the last 90 days.
(90-Day Look-back)

This is a required field.

- Record number of times the individual has fallen in the last 90 days. Enter 0 (zero) if no falls.
- Each fall should be counted separately so if the individual has fallen multiple times in one day, count each fall individually.
- Valid range includes 0 – 999.

Pediatric Tip

Code reported falls even in situations when the falls are expected, for example, a toddler learning to walk or a child with cerebral palsy.

S6i. In how many of the falls listed in S6h above was the individual physically restrained prior to the fall?

This is a required field only if S6h indicates the individual has fallen.

- Valid range includes 0 with a maximum being the number entered in S6h.
- Enter 0 if no falls when the individual was physically restrained prior to the fall.

S6j. In the falls listed in S6h above, how many had the following contributory factors?

- More than one factor may apply to a fall. Indicate the number of falls, for each contributory factor.

S6j1 through S6j6 are required fields only if S6h indicates the individual has fallen.

Valid range includes 0 with a maximum being the number entered in S6h.

1. S6j1-Environmental (debris, slick or wet floors, lighting, etc.)
2. S6j2-Medication(s)
3. S6j3-Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)
4. S6j4-Poor Balance/Weakness
5. S6j5-Confusion/Disorientation
6. S6j6-Assault by Individual or Caregiver

S7. Physician's Evaluation and Recommendation

S7a. Did an MD/DO certify that this individual requires nursing facility services or alternative community based services under the supervision of an MD/DO? Y/N

- In order to meet the requirements for these community programs, the individual **must** require nursing facility services or alternative community based services under the supervision of an MD or DO. Submission of the assessment will not be allowed on the TMHP LTC Online Portal if N (no) is selected.
- This is a required field for the Initial Assessment. This field is optional for Annual and SCSA Assessments.

S7b. Did a military physician providing healthcare according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual? Y/N

This is a required field.

- If the licensed physician providing healthcare to this individual is practicing in a health care facility of the Department of Defense (DOD), a civilian facility affiliated with the DOD, or any other location authorized by the Secretary of Defense, and is **not** licensed by the State of Texas, answer Y (yes) to this item. If the answer is Y, complete S7f through S7k.
- If the answer to this item is Y (yes) a physician name and permanent license number from any of the 50 states, the District of Columbia, or United States territories is acceptable.
- If the answer to this item is N (no) a physician name and permanent license number from the following states is acceptable: Texas, Louisiana, Arkansas, Oklahoma and New Mexico.

S7c. MD/DO Last Name

Required field

- Enter the last name of the MD/DO.

S7d. MD/DO License #

Required field

- Enter the license number of the MD/DO.
- This number is validated against the applicable State Medical Board file.
- Physicians are not required to complete the RUG training.
- Only permanent license numbers will be accepted.

S7e. MD/DO License State

Required field

- Enter the state in which the MD/DO is licensed.
- For non-military physicians, only physicians from Texas and the four states contiguous to Texas are acceptable (Louisiana, Arkansas, Oklahoma, and New Mexico).
- Indicate Physician Signature on file by checking box.
 - The box next to the statement “Indicate Physician Signature on file by checking box” is required to be checked for Initial Assessments; it is optional for Annual and SCSEA Assessments.

S7f through S7j is required information if the MD/DO is not licensed in Texas.

Enter the address and phone number of the military facility in which the physician providing the evaluation and recommendation practices in S7g-S7k. This information will be used to mail MN determination letters.

S7f. MD/DO First Name

Required field if S7e License State is NOT Texas.

- Enter the first name of the individual’s MD/DO.
- This information is used to mail MN determination letters.

S7g. MD/DO Address

Required field if S7e License State is NOT Texas.

- Enter the street address of the individual's MD/DO.
- This information is used to mail MN determination letters.

S7h. MD/DO City

Required field if S7e License State is NOT Texas.

- Enter the city of the individual's MD/DO mailing address.
- This information is used to mail MN determination letters.
- If a city has a hyphen in the city name, replace the hyphen with a space.
- If a city has an apostrophe in the city name, enter the city name without the apostrophe.

S7i. MD/DO State

Required field if S7e License State is NOT Texas.

- Enter the state of the individual's MD/DO mailing address.
- This information is used to mail MN determination letters.

S7j. MD/DO ZIP code

Required field if S7e License State is NOT Texas.

- Enter the ZIP code of the individual's MD/DO mailing address.
- This information is used to mail MN determination letters.

S7k. MD/DO Phone

Optional field if S7e License State is NOT Texas.

- Enter the phone number of the individual's MD/DO.
- This information is used to contact MD/DO if necessary.

S9. Medications

(30-Day Look-back)

Medication Certification. I certify this individual is taking no medications OR the medications listed below are correct.

Required

- Check the Medication Certification box to verify the individual has no medications OR that the individual has medications and they are listed correctly in the medication table to include name, dose, route of administration (RA), frequency (Freq), and as necessary – number of doses (PRN-n).
- The coding instructions are extensive. Review them carefully. Study the examples and complete the coding exercise at the end of this section.

1. **Medication Name and Dose Ordered.** Identify and record all medications that the individual received in the last **30 days**. Also identify and record any medications that may not have been given in the last 30 days, but are part of the individual's regular medication regimen (e.g., monthly B-12 injections). Do not record PRN medications that were not administered in the last 30 days.

- Record the name of the medication and dose that was ordered by the physician in column 1.
- Code only medications that the physician orders. If a medication is administered outside of the individual's residence, (e.g., a dose administered at an Adult Day Care facility or a dialysis center), that should be included here. (Dialysis itself is captured in O0100J.)
- When an oral medication is crushed and administered via G-tube, use code 9, enteral tube. A note of caution: some oral medications should not be crushed.
- Stat orders are coded as 1 in the PRN column.
- All medications received by the individual, including over-the-counter medications ordered by the physician should be included.
- Record the total number of doses, not days, in the last 30 days, which the PRN medication was given.

EXAMPLE FOR 1. MEDICATION NAME AND DOSE ORDERED

Medications for assessment period of 8/11/10-9/9/10

- A. Lasix 40 mg daily p.o.
- B. Acetaminophen 325 mg 2 tabs q3-4 hrs. PRN p.o. (given 3 times in last 30 days)
- C. B-12 1cc q month IM (given 8/8/10)
- D. Isopto Carbachol 1.5 percent 2 drops OD TID
- E. Robitussin-DM 5cc HS PRN p.o. (not given in last 30 days)
- F. Motrin 300 mg QID p.o. (discontinued 8/15/10)
- G. Dilantin 300 mg HS p.o. (ordered 8/15/10)
- H. Theo-Dur 200 mg BID p.o. (given 8/11-8/13/10 and then order discontinued)
- I. Theo-Dur 200 mg TID p.o. (given 8/14-8/16/10 and then order discontinued)
- J. Theo-Dur 400 mg BID p.o. (given 8/02/10)

Complete Column 1 as follows:

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Lasix 40 mg			
Acetaminophen 325 mg. 2 tabs			
B-12 1cc			
Isopto Carbachol 1.5 percent 2 drops			
Motrin 300 mg			
Dilantin 300 mg			
Theo-Dur 200 mg			
Theo-Dur 200 mg			
Theo-Dur 400 mg			

*Note that Robitussin-DM was not recorded because it was not given in the last 30 days.

2. **Route of Administration.** Determine the Route of Administration (RA) used to administer each medication. The physician's orders should identify the RA for each medication. Record the RA in column 2 using the following codes:

- | | | |
|----------------------|---------------------|----------------|
| 1=by mouth (PO) | 5=subcutaneous (SQ) | 8=inhalation |
| 2=sub lingual (SL) | 6=rectal (R) | 9=enteral tube |
| 3=intramuscular (IM) | 7=topical | 10=other |
| 4=intravenous (IV) | | |

EXAMPLE FOR 2. ROUTE OF ADMINISTRATION

Medications for assessment period of 8/11/10-9/9/10

- A. Mylanta 15 cc after meals p.o.
- B. Zantac 150 mg q 12 hrs. Per tube
- C. Transderm Nitro patch 2.5 1 patch daily
- D. NPH 15 U before breakfast daily SQ
- E. Lasix 80 mg IV STAT
- F. Acetaminophen suppository 650 mg. q 4 hrs. PRN (given on 2 occasions in last 30 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Mylanta 15 cc	1		
Zantac 150 mg	9		
Transderm Nitro patch 2.5 1 patch	7		
NPH 15 U	5		
Lasix 80 mg	4		
Acetaminophen suppository 650 mg	6		

3. **Frequency.** Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3 using the following codes:

- | | | |
|----------------------------|----------------------------|---------------------------------|
| PR=(PRN) as necessary | 2D=(BID) two times daily | QO=every other day |
| 1H=(QH) every hour | (includes every 12 hrs.) | 4W=4 times each week 2H=(Q2H) |
| every two hours | 3D=(TID) three times daily | 5W=five times each week |
| 3H=(Q3H) every three hours | 4D=(QID) four times daily | 6W=six times each week 4H=(Q4H) |
| every four hours | 5D=five times daily | 1M=(Q mo) once every month |
| 6H=(Q6H) every six hours | 1W=(Q week) once each wk | 2M=twice every month 8H=(Q8H) |
| every eight hours | 2W=two times every week | C=continuous |
| 1D=(QD or HS) once daily | 3W=three times every week | O=other |

Be careful to differentiate between similar frequencies. For example, if an antibiotic is ordered as T.I.D., the medication may actually be given q 8 hours. There is a different frequency code for T.I.D. (3D) and q 8 hrs. (8H). If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

EXAMPLE FOR 3. FREQUENCY

Medications for assessment period of 8/11/10-9/9/10

- A. Ampicillin 250 mg q 6 hrs. x 10 days p.o. (8/10-8/20/10)
- B. Beconase nasal inhaler 1 puff BID
- C. Compazine suppository 5 mg. STAT
- D. Lanoxin 0.25 mg p.o. every other day. On alternate days, give Lanoxin 0.125 mg. p.o.
- E. Peri-colace 2 capsules HS p.o.
- F. NPH 15 U before breakfast daily SQ
- G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/10 for BS of 255; 5 units given on 8/13/10 for BS of 233; 10 units given on 8/17/10 for BS of 305)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Ampicillin 250 mg	1	6h	
Beconase nasal inhaler 1 puff	8	2d	
Compazine suppository 5 mg	6	PR	
Lanoxin 0.25 mg	1	QO	
Lanoxin 0.125 mg	1	QO	
Peri-colace 2 capsules	1	1D	
NPH 15 U	5	1D	
NPH 5 U	5	PR	
NPH 10 U	5	PR	

4. **PRN-Number of Doses (PRN-n).** The PRN-n column is only completed for medications that have a frequency as PR. Record the number of times in the past 30 days that each medication coded as PR was given. Stat medications are recorded as a PRN medication. Remember, if a PRN medication was not given in the past 30 days, it should not be listed here.

Coding Exercises for S9 Medications

Complete the practice form on the next page for the following medications during a 30-day period (8/11/10-9/9/10):

- 1. Inderal 40 mg BID p.o.
- 2. Sinemet 10/100 TID p.o.
- 3. Artificial Tears 1 drop OU QID
- 4. Anusol HC suppository 1 PRN (given 1 time in last 30 days)
- 5. Amoxicillin 500 mg q 6 hrs. per tube
- 6. Benylin cough syrup 2 tbs PRN p.o. (given 10 times in last 30 days)
- 7. Darvocet-N 100 2 tabs q 4-6 hrs. PRN p.o. (given 5 times in last 30 days)
- 8. Heparin lock flush 10 U daily
- 9. Ditropan syrup 2.5 mg daily p.o.

S9. Medications exercise answer form.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Inderal 40 mg.	1	2D	
Sinemet 10/100	1	3D	
Artificial Tears 1 drop	7	4D	
Anusol HC suppository 1	6	PR	1
Amoxicillin 500 mg	9	6H	
Benylin cough syrup 2 Tbs	1	PR	10
Darvocet-N 100 2 tabs	1	PR	5
Heparin lock flush 10 U	4	1D	
Ditropan syrup 2.5 mg	1	1D	
Nitrotransdermal .4 mg	7	1D	
Novolin N 24 U	5	1D	
Novolin R 10 U	5	PR	2
Questran 1 packet	1	3D	
Quinine sulfate 325 mg	1	1D	
Coumadin 2.5 mg	1	1D	
Coumadin 5 mg	1	1D	

S10. Comments

Enter up to 1,500 characters if needed. The information entered must not conflict with the information entered in Cognitive Patterns and the other sections of the MN/LOC Assessment. It is essential that you include signs and symptoms that present an accurate picture of the individual's condition. The comment section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:

- Pertinent medical history
- Ability to understand medications
- Ability to understand changes in condition
- Abnormal vital signs
- Abnormal lab work results

Pediatric Tip

When chest physiotherapy techniques (CPT) including percussion and postural drainage, use of a high-frequency chest wall oscillation device (ThAIRapy® Vest), intrapulmonary percussive ventilator (IPV) are administered by an individual who is not a licensed Respiratory Therapist (i.e. an RN, LVN, or trained caregiver) it should be noted in Comments.

Nebulizer treatments administered by family members (or other individuals, non-licensed or not delegated to under the license of a nurse) are not coded in O0400D1; in this case nebulizer treatments should be entered in section S9, Medications, and may also be noted in Comments.

S11. Advance Care Planning

What is Advance Care Planning?

Advance care planning means planning ahead for how the individual wants to be treated if ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die they are not able to talk or to let others know how they feel.

Advance care planning is a 5-step process that should be discussed with the individual.

1. Thinking about what you would want to happen if you could not talk or communicate with anyone
2. Finding out about what kind of choices you will need to make if you become very ill at home, in a nursing home or in a hospital
3. Talking with your family and doctor about how you want to be treated
4. Filling out papers that spell out what you want if you are in an accident or become sick
5. Telling people what you have decided

S11a. Does the individual/caregiver report that the individual has a legally authorized representative? Y/N

- Legally Authorized Representative is a person authorized by law to act on behalf of a person with regard to a matter described in this chapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult. A parent is authorized by law to act on behalf of their minor child.
- Required field and correctable.
Enter Y = Yes.
Enter N = No.

S11b. Does the individual/caregiver report that the individual has a Directive to Physicians and Family or Surrogates?

- Directive to Physician is a document that communicates an individual's wishes about medical treatment at some time in the future when he or she is unable to make their wishes known because of illness or injury.
- Required field and correctable.
Enter Y = Yes.
Enter N = No.

S11c. Does the individual/caregiver report that the individual has a Medical Power of Attorney?
Required field and correctable

- Enter Y = Yes.
Enter N = No.

S11d. Does the individual/caregiver report that the individual has an Out-of-Hospital Do-Not-Resuscitate Order?

- What is an Out-of-Hospital Do Not Resuscitate Order (OOHDNR)?
This form is for use when an individual is not in the hospital. It lets the person tell health care workers, including Emergency Medical Services (EMS) workers, NOT to do some things if the person stops breathing or their heart stops. If an individual does not have one of

these forms filled out, EMS workers will ALWAYS give the person Cardiopulmonary Resuscitation (CPR) or advanced life support even if the advance care planning forms say not to. A person should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power of Attorney form if they do NOT want CPR.

- Required field and correctable.
Enter Y = Yes.
Enter N = No.

S12. LAR Address

Legally Authorized Representative (LAR) address and name are required if S11a Is indicated as 1 – Yes, Does the individual report having a legally authorized representative?

S12a. LAR First Name

- Enter the first name of the Legally Authorized Representative.

S12b. LAR Last Name

- Enter the last name of the Legally Authorized Representative.

S12c. Address

- Enter the street address of the Legally Authorized Representative.

S12d. City

- Enter the city of the Legally Authorized Representative.
- If a city has a hyphen in the city name, replace the hyphen with a space.
- If a city has an apostrophe in the city name, enter the city name without the apostrophe.

S12e. State

- Enter the state of the Legally Authorized Representative.

S12f. ZIP Code

- Enter the zip code of the Legally Authorized Representative.

S12g. Phone

Optional

- Enter the contact phone number for the Legally Authorized Representative if known.

Appendix I – RUG Items

Number	Description
A0310A	Reason for Assessment
B0100	Comatose
B0700	Makes Self Understood
C0500	Cognitive Patterns Summary Score
C0700	Short-term Memory OK
C1000	Cognitive Skills for daily decision making
D0300	Individual Mood Interview
D0600	Individual Mood Interview (by Caregiver)
E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral systems directed toward others
E0200B	Verbal behavioral symptoms directed toward others
E0200C	Other behavioral symptoms not directed toward others
E0800	Rejection of Care
E0900	Wandering - Presence and Frequency
G0110A1	Bed Mobility - Self performance
G0110A2	Bed Mobility - Support
G0110B1	Transfer - Self performance
G0110B2	Transfer - Support
G0110H1	Eating - Self performance
G0110I1	Toilet Use - Self performance
G0110I2	Toilet Use - Support
H0200C	Current continence promotion program or trial
H0500	Bowel continence program
I2000	Pneumonia
I2100	Septicemia
I2900	Diabetes Mellitus
I4300	Aphasia
I4400	Cerebral Palsy
I4900	Hemiplegia or Hemiparesis
I5100	Quadriplegia
I5200	Multiple Sclerosis (MS)
J1550A	Fever
J1550B	Vomiting
J1550C	Dehydrated
J1550D	Internal bleeding
K0300	Weight Loss
K0510A	Parenteral/IV feeding
K0510B	Feeding-tube
K0710A	Proportion of total calories the individual received through parenteral or tube feeding
K0710B	Average fluid intake per day by IV or tube feeding
M0300A	Number of Stage 1 ulcers
M0300B1	Number of Stage 2 ulcers

M0300C1 Number of Stage 3 ulcers
M0300D1 Number of Stage 4 ulcers
M0300F1 Number of unstageable - slough and/or eschar
M1030 Number of Venous and Arterial ulcers
M1040A Infection of the foot
M1040B Diabetic foot ulcer/injury
M1040C Other open lesion(s) on the foot
M1040D Open lesion(s) other than ulcers, rashes, cuts
M1040E Surgical wound(s)
M1040F Burn(s)
M1200A Pressure reducing device for chair
M1200B Pressure reducing device for bed
M1200C Turning/repositioning program
M1200D Nutrition or hydration intervention
M1200E Ulcer Care
M1200F Surgical wound care
M1200G Application of nonsurgical dressings
M1200H Applications of ointments/medications
M1200I Application of dressings to feet
N0300 Injections
O0100A Chemotherapy
O0100B Radiation
O0100C Oxygen Therapy
O0100D Suctioning
O0100E Tracheostomy care
O0100F Ventilator or respirator
O0100H IV medications
O0100I Transfusions
O0100J Dialysis
O0400A1 Speech-Language pathology and Audiology Services - Individual minutes
O0400A2 Speech-Language pathology and Audiology Services - Concurrent minutes
O0400A3 Speech-Language pathology and Audiology Services - Group minutes
O0400A4 Speech-Language pathology and Audiology Services - Days
O0400B1 Occupational Therapy - Individual minutes
O0400B2 Occupational Therapy - Concurrent minutes
O0400B3 Occupational Therapy - Group minutes
O0400B4 Occupational Therapy - Days
O0400C1 Physical Therapy - Individual minutes
O0400C2 Physical Therapy - Concurrent minutes
O0400C3 Physical Therapy - Group minutes
O0400C4 Physical Therapy - Days
O0400D2 Respiratory Therapy - Days
O0500A Restorative Nursing Programs - Range of motion (passive)
O0500B Restorative Nursing Programs - Range of motion (active)
O0500C Restorative Nursing Programs - Splint or brace assistance
O0500D Restorative Nursing Programs - Bed mobility

O0500E Restorative Nursing Programs - Transfer
O0500F Restorative Nursing Programs-Walking
O0500G Restorative Nursing Programs - Dressing and/or grooming
O0500H Restorative Nursing Programs - Eating and/or swallowing
O0500I Restorative Nursing Programs - Amputation/prostheses care
O0500J Restorative Nursing Programs - Communication
O0600 Physician Examinations
O0700 Physician Orders

Appendix II – Revisions Table

Date	Action	Section	Change
June 25, 2010	Revised	Footnote, Overview, & Table of Contents	Added "3.0"
June 25, 2010	Added	Overview- Coding Conventions	Added statement: Responses entered on the LTCMI should not conflict with other sections of the 3.0 MN/LOC Assessment
June 25, 2010	Added	Overview- Coding Conventions	Added statement: The Assessment Date (A2300) establishes the endpoint for all look-back periods.
June 25, 2010	Revised	LTCMI S2f	Changed Look-back to Lookback
June 25, 2010	Added	LTCMI S2g	Added instruction for non-HCSSA nurse completing this field
June 25, 2010	Added	LTCMI S3a	Added instruction regarding Primary Diagnosis code
June 25, 2010	Removed	LTCMI S6g	Removed statement regarding no conflicts
June 25, 2010	Revised	LTCMI S7d	Changed "Texas" to "State"
June 25, 2010	Added	I8000	Added instruction regarding Sexually Transmitted Disease reporting
June 25, 2010	Revised	Table of Contents, Overview & Section O	Changed section title from "Special Treatments and Procedures" to "Special Treatments, Procedures, and Programs"
June 25, 2010	Revised	Appendix I	Corrected description of O0500F to Restorative Nursing Programs - Walking
June 25, 2010	Added	Appendix II	Added Revisions Table
Sept. 23, 2010	Added	Through out	Minor word changes to be consistent with the MDS instructions
Sept. 23, 2010	Revised	Table of Contents	Clarified RUG items

Date	Action	Section	Change
Sept. 23, 2010	Added	B1200 Corrective Lenses	Added to Steps for Assessment- Visual aids do not include surgical lens implants
Sept. 23, 2010	Added	C0200-C0500	Added bullet to Coding Tips, added tip to code nonsensical answers as 0
Sept. 23, 2010	Revised	C0200-C0500 Steps For Assessment	Revised Step 9
Sept. 23, 2010	Revised	D0350 Safety Notification	Revised Coding Tips
Sept. 23, 2010	Revised	D0650 Safety Notification	Revised Coding Tips
Sept. 23, 2010	Added	D0300 Total Severity Score	Added note regarding how Total Severity Score is auto calculated
Sept. 23, 2010	Revised	E Behavior Intent	New language regarding emphasis
Sept. 23, 2010	Revised	E0800 Rejection of Care	Revised Health Related Quality of Life section
Sept. 23, 2010	Revised	E0900 Steps for Assessment	Revised definition of wandering
Sept. 23, 2010	Revised	E1000 Wandering-Impact	Revised Steps for Assessment
Sept. 23, 2010	Added	G0110I ADL Assistance Toilet Use	Added does not include emptying bedpan...
Sept. 23, 2010	Added	G0110 ADL Assistance	Added clarifying words to ADL Self Performance Coding Flow Diagram
Sept. 23, 2010	Added	H0600 Bowel Patterns	Added fecal impaction to Coding Instructions
Sept. 23, 2010	Revised	I2300 Urinary Tract Infection	Revised coding tips regarding when a urinary tract infection can be coded

Date	Action	Section	Change
Sept. 23, 2010	Added	Blood Pressure Readings- I0799a, I0799b, I0899a, I0899b	Added instructions
Sept. 23, 2010	Added	Section H Bladder and Bowel	Added to the Intent
Sept. 23, 2010	Removed	Section H Bladder and Bowel	Removed the times from the definition of Intermittent Catheterization in H0100
Sept. 23, 2010	Added	Section H Bladder and Bowel	Added coding tip to H0100 do not code 1x catheterization as intermittent
Sept. 23, 2010	Added	Section H Bladder and Bowel	Added coding tip to H0600 Bowel Patterns: fecal impaction is constipation
Sept. 23, 2010	Added	Section I Active Diagnoses	Added a coding tip regarding active diagnosis and UTIs.
Sept. 23, 2010	Added	J0800 Indicators of Pain or Possible Pain	Added "included but not limited to" to Coding Instructions in A-D
Sept. 23, 2010	Added	J1550 Problem Conditions	Added tip regarding conditions not to code as Internal Bleeding J1550D
Sept. 23, 2010	Added	K0500 Swallowing/Nutritional Status	Added coding tip to K0500A regarding IV fluids
Sept. 23, 2010	Revised	K0500 Swallowing/Nutritional Status	Revised coding tip K0500D regarding enteral formulas
Sept. 23, 2010	Added	M0100 Determination of Pressure Ulcer/injury Risk	Added bullet to Planning for Care
Sept. 23, 2010	Revised	M0700 Most Severe Tissue Type...	Revised coding tip for Stage 2
Dec. 2, 2010	Added	Overview	Added clarifying statement about RUG calculation to MN/LOC Purpose
Dec. 2, 2010	Added	B0800 Ability to Understand Others	Added Pediatric Tip

Date	Action	Section	Change
Dec. 2, 2010	Added	C1600 Acute Onset Mental Status Change	Added Coding Tip
Dec. 2, 2010	Added	G0900B Functional Rehabilitation Potential	Added Coding Instruction to follow if no caregiver is available
Dec. 2, 2010	Added	G0600 Mobility Devices	Added Pediatric Tip
Dec. 2, 2010	Added	J1550D Problem Conditions	Added definition for Internal Bleeding
Dec. 2, 2010	Added	H0300 Urinary Continence	Added Pediatric Tip
Dec. 2, 2010	Added	H0400 Bowel Incontinence	Added Pediatric Tip
Dec. 2, 2010	Added	O0400 Therapies	Added information regarding start date under Coding Tips and Minutes of Therapy
Dec. 2, 2010	Added	O0400 Therapies	Added note under Planning for Care regarding where to code nebulizer treatments administered family members & others non-licensed
Dec. 2, 2010	Added	S7 Physician's Evaluation & Recommendation	Added information regarding acceptable MD/DO license states and permanent license number required to S7b, S7d, and S7e
Dec. 2, 2010	Added	S10 Comments	Added Pediatric Tip regarding coding of nebulizer treatments
March 1, 2011	Removed	Overview & LTCMI	Removed references to Integrated Care Management Waiver (ICMW)
March 1, 2011	Changed	Overview- Assessment Retention	Keep in accordance with applicable rules
March 1, 2011	Added	S7 Physician's Evaluation and Recommendation	Added District of Columbia
March 1, 2011	Added	Cognitive Patterns- Intent & S10 Comments	Information entered regarding cognitive status/memory must be consistent in these two sections

Date	Action	Section	Change
Nov. 1, 2011	Added	C0200 Repetition of Three Words, Steps for Assessment	Added instructions for the interviewer
Nov. 1, 2011	Added	E0800 Rejection of Care, Coding Tips and Special Populations	Added instructions regarding individuals making an informed choice
Nov. 1, 2011	Removed	G0300 Balance During Transitions and Walking, Definitions	Removed the hyphen from Interdisciplinary (Team)
Nov. 1, 2011	Added	G0300D Balance During Transitions and Walking, Moving on and off toilet r	Added "If lift device is used" to coding instructions for G0300D
Nov. 1, 2011	Added	G0400 Functional Limitation in Range of Motion, Coding Tips	Added tip regarding individuals with amputations
Nov. 1, 2011	Added	Section I Active Diagnoses, Steps for Assessment	Added instruction regarding "new normal" under #2. Determine whether diagnoses are active.
Nov. 1, 2011	Added	Section I Active Diagnoses, Definitions	Added "physician-documented" under the definition of Active Diagnoses
Nov. 1, 2011	Changed	J1400 Prognosis, Definitions	Changed the definition of Hospice Services
Nov. 1, 2011	Added	J1400 Prognosis, Definitions	Added definition for Terminally Ill
Nov. 1, 2011	Changed	J1400 Prognosis, Coding Instructions	Changed coding instructions
Nov. 1, 2011	Added	K0300 Weight Loss	Added definition for Physician-Prescribed Weight-Loss Regimen
Nov. 1, 2011	Changed	K0300 Weight Loss, Coding Instructions	Changed instructions for Code 1, yes...
Nov. 1, 2011	Changed	K0300 Weight Loss, Coding Tips	Changed Coding Tip
Nov. 1, 2011	Added	K0500 Nutritional Approaches	Added definitions for Mechanically Altered Diet and Therapeutic Diet
Nov. 1, 2011	Added	K0500 Nutritional Approaches, Coding Tip	Added Coding Tip regarding nutritional supplements

Date	Action	Section	Change
Nov. 1, 2011	Changed	M1040 Other Ulcer/injurys, Wounds and Skin Problems, Coding Instructions	Added example of cuts, fissures to Coding Instructions for M1040C
Nov. 1, 2011	Added	M1040 Other Ulcer/injurys, Wounds and Skin Problems, Coding Instructions	Added coding Instructions for M1040E, surgical wounds
Nov. 1, 2011	Changed	M1200 Skin and Ulcer/injury Treatments, Definitions	Changed the word supplements to supplementation
Nov. 1, 2011	Added	M1200D Skin and Ulcer/injury Treatments, Coding Tip	Added coding tip to Nutrition or hydration intervention to manage skin problems
Nov. 1, 2011	Changed	M1200G Skin and Ulcer/injury Treatments- Application of nonsurgical dressings, Coding Tips	Clarified coding tip language
Nov. 1, 2011	Added	M1200G Skin and Ulcer/injury Treatments- Application of nonsurgical dressings, Coding Instructions and Coding Tips	Added instruction and tip – this item does not include Band-Aids
Nov. 1, 2011	Changed	N Medications, Intent	Clarified injection types
Nov. 1, 2011	Changed	N0300 Injections, Coding Instructions	Clarified injection types
Nov. 1, 2011	Added	O0100 Special Treatments and Procedures, Coding Instructions	Added Coding Instructions for O0100C, O0100D, O0100E, O0100G, O0100J instructing to code if the individual performs self-care
Nov. 1, 2011	Removed	LTCMI, S5	Removed the word review after UR in several places
Nov. 1, 2011	Changed	LTCMI, S7d	Clarified by adding the word applicable
May 1, 2012	Changed	Table of Contents	Changed K0500A to K0510A and Changed K0500B to K0510B
May 1, 2012	Removed	Overview to the MN/LOC	Removed Consolidated Waiver Program

Date	Action	Section	Change
May 1, 2012	Changed	B1000 Vision	In option 0, changed the word including to the words such as
May 1, 2012	Changed	E1000 Potential Indicators of Psychosis	Changed the item heading to Potential Indicators of Psychosis
May 1, 2012	Changed	E0800 Rejection of Care	Changed word and/or to and
May 1, 2012	Changed	G0110 ADL Self Performance and ADL Support Provided	Changed wording for coding option 8, Activity did not occur
May 1, 2012	Changed	G0110 Activities of Daily Living (ADL) Assistance	Changed Instructions for Rule of Three to be consistent with option 8 change
May 1, 2012	Changed	G0120A Bathing, Self Performance	Changed wording for coding option 8, Activity did not occur
May 1, 2012	Changed	G0300E Surface to Surface Transfer	Clarified Coding Instructions and Examples
May 1, 2012	Changed	H0600 Bowel Patterns, Coding Tips and Special Populations	Changed information about fecal impaction
May 1, 2012	Added	I Active Diagnoses	Added definition for Nursing Monitoring
May 1, 2012	Changed	I Active Diagnoses	Clarified wording under Intent
May 1, 2012	Changed	I4800 Neurological Active Diagnoses	Changed item heading from Dementia to Non-Alzheimer's Dementia and clarified definition
May 1, 2012	Changed	J0100A and J0100B Pain Management	Changed the word been to received
May 1, 2012	Added	K0310 Weight Gain	Added new field
May 1, 2012	Removed	K0500 Nutritional Approaches	Replaced with K0510
May 1, 2012	Added	K0510 Nutritional Approaches	Replaces K0500, content is the same
May 1, 2012	Changed	K0700 Most Severe Tissue Type for Any Pressure Ulcer/injury	Added option 9, None of the Above

Date	Action	Section	Change
May 1, 2012	Added	M1040G Skin Tear(s)	New field
May 1, 2012	Added	M1040H Moisture Associated Skin Damage (MASD)	New field
May 1, 2012	Changed	M1200E Ulcer/injury care	Changed to Pressure ulcer/injury care
May 1, 2012	Changed	N0300 Injections	Skip instructions updated
May 1, 2012	Removed	N0400 Medications Received	Replaced with N0410
May 1, 2012	Added	N0410 Medications Received	Respond with number of days medication received, previous version had check boxes
May 1, 2012	Changed	N0410 Medications Received, Definitions	Revised definitions for Adverse Consequence, Non-Pharmacological Intervention, Monitoring, Gradual Dose Reduction, and Medication Interaction
May 1, 2012	Changed	Q0100B and Q0100C Participation in Assessment	Added the word available to option 9
May 1, 2012	Changed	Q0100 Participation in Assessment	Clarified Health-related Quality of Life
May 1, 2012	Changed	Q0300 Participation in Assessment	Q0300A change to Coding Instructions option 9 and change to Coding Tip
May 1, 2012	Changed	Q0300 Participation in Assessment	Q0300B change to Coding Instructions option 9
May 1, 2012	Changed	Appendix I, RUG Items	Changed K0500A to K0510A and Changed K0500B to K0510B
October 25, 2012	Changed	Overview, Medical Necessity and Level of Care Assessment Purpose	Additional information about RUG and MN
October 25, 2012	Changed	C0500 Steps for Assessment	Added information about when to administer the BIMS in writing

Date	Action	Section	Change
October 25, 2012	Changed	C0500 Coding Instructions and Coding Tips	New information about what is considered a complete interview (BIMS).
October 25, 2012	Changed	C0600 Coding Instructions and Coding Tips	New information about when to code 1, yes, Should Caregiver Assessment for Mental Status be Conducted.
October 25, 2012	Changed	G0110 Activities of Daily Living Assistance: 1.Self-Performance & 2.Support	Changed coding option 8 to pre May 1, 2012 wording
October 25, 2012	Changed	G0120 Bathing	Changed coding option 8 to pre May 1, 2012 wording
October 25, 2012	Removed	S2c and S5a, S5b, and S5c	Removed references to CWP, Service Group 17
October 25, 2012	Removed	S5d, S5e, S5f, and S5g- DADS RN	Removed Purpose Code L (Lookback)
October 2013	Added	Medical Necessity and Level of Care Assessment Purpose	the Home and Community Based Services STAR+PLUS Waiver (SPW)
October 2013	Removed	Medical Necessity and Level of Care Assessment Purpose	State of Texas Access Reform Plus (STAR+PLUS)
October 2013	Added	Medical Necessity and Level of Care Assessment Purpose	A determination that an individual meets MN is required for an individual to participate in CBA, MDCP, PACE, and SPW.
October 2013	Added	Medical Necessity and Level of Care Assessment Purpose	and SPW
October 2013	Removed	When to Complete an Assessment	Use the Medical Necessity and Level of Care Assessment to submit assessment information necessary for TMHP to determine: 1) medical necessity and 2) RUG.
October 2013	Removed	Coding conventions 3 rd bullet	should
October 2013	Added	Coding Conventions 3 rd bullet	must

Date	Action	Section	Change
October 2013	Removed	Coding Instructions for A0310, Type of Assessment	required
October 2013	Added	Coding Instructions for A0310, Type of Assessment	completed
October 2013	Added	Coding Instructions for A0310, Type of Assessment (01.)	Please refer to the specific Community Program handbook or rules to determine if an MN/LOC must be completed for individuals transitioning from a Nursing Facility (NF) to a specific Community Program. In some instances, the MN and RUG determined by the Nursing Facility (NF) assessment (the Minimum Data Set [MDS]) may be valid for the Community Program.
October 2013	Removed	Coding Instructions for A0310, Type of Assessment (01.)	The one exception is for an individual who is transitioning to a Community Program from a Nursing Facility (NF). In this situation the medical necessity (MN) already established by the NF transitions with the individual to the Community Program. An Initial Assessment can only be done on transitioning individuals if it is authorized by the DADS case manager.
October 2013	Added	Coding Instructions for A0310, Type of Assessment (04.)	(SCSA)
October 2013	Removed	Coding Instructions for A0310, Type of Assessment (04.)	A Significant Change in Status Assessment (SCSA) must be authorized by a DADS case manager prior to submission
October 2013	Removed	Coding Instructions for A0310, Type of Assessment (04.)	For the purposes of a SCSA
October 2013	Added	Coding Instructions for A0310, Type of Assessment (04.)	For the purposes of this assessment process,

Date	Action	Section	Change
October 2013	Removed	Coding Instructions for A0310, Type of Assessment (04.)	impact
October 2013	Added	Coding Instructions for A0310, Type of Assessment (04.)	increase
October 2013	Added	Coding Instructions for A0310, Type of Assessment (04.)	A SCSA does not apply for PACE. For CBA, MDCP, and SPW refer to the program handbook to determine if a SCSA must be authorized prior to submission on the TMHP LTC Online Portal.
October 2013	Removed	Coding Instructions for A0310, Type of Assessment (04.)	A SCSA does not apply for PACE
October 2013	Added	Coding Tips and Special Populations, Page 13	should
October 2013	Removed	Coding Tips and Special Populations, Page 13	must
October 2013	Added	Definition IDD, Page 16 and 17	<p>Down syndrome – A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, intellectual disability, low muscle tone, and other possible effects.</p> <p>Autism – A developmental disorder that is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.</p> <p>Epilepsy – A common chronic neurological disorder that is characterized by recurrent unprovoked seizures.</p>

Date	Action	Section	Change
October 2013	Removed	Pediatric Tip, Page 25	Code all the modes child is able to use. If unable to use any of the listed modes of expression, code Z-none of the above.
October 2013	Added	Pediatric Tip, Page 25	Coding Instructions (heading)
October 2013	Added	Pediatric Tip, Page 27 (second bullet)	indicating the item was not assessed
October 2013	Added	C0100 - Page 31 Steps for Assessment (step 1)	If rarely/never understood, skip to C0700-C1000, Caregiver Assessment for Mental Status.
October 2013	Removed	C0100 - Page 31 Steps for Assessment	3.The BIMS should be conducted if the individual can respond: <ul style="list-style-type: none"> • Verbally; or • by writing out his or her answers.
October 2013	Removed	Coding Tip, page 37	caregiver
October 2013	Added	Coding Tip, page 37	interviewer
October 2013	Removed	Coding Tip, page 37	If no other caregiver can complete the interview and the individual can read, the caregiver may write those words on a piece of paper, large enough to be easily seen, and ask the individual to read the word(s). After taking the paper away, the interviewer should ask the individual to repeat the word(s). Record the number of words the individual repeated correctly on the first attempt. The interviewer can then proceed giving cues as described under “Steps for Assessment.”
October 2013	Added	Coding Instructions, Page 45	The total possible BIMS score ranges from 00 to 15

Date	Action	Section	Change
October 2013	Replaced	C1600 - Acute Onset of Mental Status Change	Replaced current C100 Acute Onset of Mental Status screenshot with updated one.
October 2013	Removed	Steps for Assessment, page 76	<p>Steps for Assessment</p> <p>After completing items D0500 A-J:</p> <ol style="list-style-type: none"> 1. Add the numeric scores across all frequency items for Caregiver Assessment of Mood, Symptom Frequency (D0500) Column 2. <p>Maximum score is 30 (3 × 10)</p>
October 2013	Added	Health-related Quality of Life, Page 89, last bullet	<ul style="list-style-type: none"> • It is really a matter of choice. When rejection/decline of care is first identified it should be investigated and determined whether the rejection/decline of care is a matter of the individual's choice. Education should be provided and the individual's choices become part of the plan of care. On future assessments, this behavior would not be coded in this item.
October 2013	Added	How to Complete and Submit an Assessment (Page 8)	Info re renewal of RN license and the MN/LOC submission
October 2013	Removed	Coding Tips and Special Populations, 2 nd bullet	Wandering may occur even if the individual is closely supervised.
October 2013	Removed	E1000: Wandering—Impact Health-related Quality of Life, 1 st bullet	Distinguish between wandering that is an adaptive or valued behavior versus wandering that represents a behavioral problem with a negative impact on the individual or others.

Date	Action	Section	Change
October 2013	Removed	Coding Instructions for E1000B. Does the Wandering Significantly Intrude on the Privacy or Activities of Others? Coding Tips and Special Populations	Coding Tips and Special Populations The term “significant” refers to effects, results, or consequences that materially affect or are likely to affect an individual’s physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.
October 2013	Replaced	G0900: Functional Rehabilitation Potential	Inserted updated screenshot and text G0900: Functional Rehabilitation Potential portion of the assessment.
October 2013	Replaced	Active Diagnoses in the Last 7 Days Section I of the assessment	Inserted updated screenshot of the Section I – Active Diagnoses portion of the assessment.
October 2013	Added	Determine whether diagnoses are active, page 144, #2	Active diagnoses are diagnoses that have a direct relationship to the individual’s current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the seven-day look-back period. D
October 2013	Added	Determine whether diagnoses are active, page 144, #2	do not affect the individual’s current status, or do not drive the plan of care during the seven-day look-back period, as these would be considered inactive diagnosis.
October 2013	Removed	Determine whether diagnoses are active, page 144, #2	or have no longer affected the individual’s current functioning or plan of care, or that the individual has adjusted to as their “new normal,” during the last 7 days.
October 2013	Removed	Health-Related Quality of Life - Coding Instructions, 5 th bullet	Check the “Other” box (I8000) and

Date	Action	Section	Change
October 2013	Added	Health-Related Quality of Life - Coding Instructions, 5th bullet	enter
October 2013	Removed	Health-Related Quality of Life - Coding Instructions, 5th bullet	write in
October 2013	Removed	Health-Related Quality of Life - Coding Instructions, 5th bullet	And name
October 2013	Added	Examples for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?" - #4	Proceed to items J0600 and J0700.
October 2013	Added	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5 th bullet	Numeric Rating Scale
October 2013	Removed	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	0-10
October 2013	Removed	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	v
October 2013	Added	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	V
October 2013	Removed	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	d
October 2013	Added	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	D
October 2013	Removed	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	s
October 2013	Added	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	S

Date	Action	Section	Change
October 2013	Added	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 6th bullet	Numeric Rating Scale,
October 2013	Removed	J0600: Pain Intensity (5-Day Look-Back) – Steps for Assessment, 5th bullet	0-10 scale
October 2013	Added	Coding Instructions for J0600B. Verbal Descriptor Scale - Code 9, unable to answer	Proceed to item J0700.
October 2013	Removed	Coding Instructions for J0600B. Verbal Descriptor Scale	Pediatric Tips: J0600: The Wong Baker FACES Pain Rating Scale is a useful tool to help a child answer this question. http://www.partnersagainstpain.com/printouts/A7012AS6.pdf
October 2013	Added	J0700: Should the Caregiver Assessment for Pain be Conducted? (5-Day Look-Back)	Item J0700 closes the pain interview and determine if the individual interview was complete or incomplete and based on this determination, whether a caregiver assessment needs to be completed.
October 2013	Removed	J0700: Should the Caregiver Assessment for Pain be Conducted? (5-Day Look-Back)	Complete this item only if the Pain Assessment Interview (J0200-J0600) was not completed.
October 2013	Removed	J0700: Should the Caregiver Assessment for Pain be Conducted? (5-Day Look-Back) – Steps for Assessment	And follow the instructions.
October 2013	Added	J0700: Should the Caregiver Assessment for Pain be Conducted? (5-Day Look-Back) – Steps for Assessment #2	2. The Caregiver Assessment for Pain should only be completed if the Pain Assessment Interview (J0200-J0600) was not completed.

Date	Action	Section	Change
October 2013	Added	Coding Instructions for J0700. Should the Caregiver Assessment for Pain be Conducted?	This item is to be coded at the completion of items J0400-J0600.
October 2013	Removed	Coding Instructions for J0700. Should the Caregiver Assessment for Pain be Conducted? – Pediatric Tip	A useful tool to evaluate pain in children is the FLACC (Face, Legs, Activity, Cry, Consolability) Scale. Texas Children’s Cancer Center, Texas Children’s Hospital, Houston, TX; Cancer Pain Management in Children http://www.childcancerpain.org/contents/childpainmgmt.pdf
October 2013	Added	J1550: Problem Conditions - Definitions	Fever – is defined as a temperature 2.4 degrees F higher than baseline.
October 2013	Added	J1550: Problem Conditions – Definitions – Internal Bleeding	, menses, or a urinalysis that shows a small amount of red blood cells
October 2013	Removed	J1550: Problem Conditions – Coding Tips	Fever: A temperature of 100.4 degrees F (38 degrees C) is considered a fever.
October 2013	Removed	J1550: Problem Conditions – Coding Tips	Internal Bleeding: Nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding.
October 2013	Added	J1700: Fall History	An intercepted fall occurs when the individual would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.
October 2013	Removed	J1700: Fall History – Steps for Assessment, #2	community

Date	Action	Section	Change
October 2013	Removed	K0200: Height and Weight (30-Day Look-back for Weight) - Definitions	<p>Parenteral/IV feeding – Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).</p> <p>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.</p> <p>Mechanically altered diet – A diet specifically prepared to alter the texture of consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.</p> <p>Therapeutic diet – A diet ordered to manage problematic health conditions. Therapeutic refers to the nutritional content of the food. Examples include calorie-specific, low-salt, lactose free, no added sugar, and supplements during meals.</p>

Date	Action	Section	Change
October 2013	Removed	Steps for Assessment for K0200A, Height	<p>4. If an individual is unable to lie flat in bed (e.g., because of contractures), measure the individual's frame, starting at the top of the head, along the spine, and following the bone structure in the legs to the bottom of the foot.</p> <p>5. If an individual cannot stand to obtain a current height or is missing limbs, use another means of determining height in accordance with current standards of clinical practice.</p>
October 2013	Removed	Coding Instructions for K0200B, Weight	<ul style="list-style-type: none"> • Weight recorded on the assessment should not be older than 30 days.
October 2013	Added	K0510: Nutritional Approaches - Definitions	<p>Parenteral/IV feeding – Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).</p> <p>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.</p>
October 2013	Added	K0510: Nutritional Approaches – Planning for Care	to validate effectiveness
October 2013	Added	K0510: Nutritional Approaches – Coding Tips	<ul style="list-style-type: none"> o IV fluids running at KVO (Keep Vein Open) o IV fluids contained in IV Piggybacks

Date	Action	Section	Change
October 2013	Removed	K0510: Nutritional Approaches – Coding Tips	unless there is a documented need for additional fluid intake for nutrition and/or hydration. This supporting documentation should be noted in the individual’s record, according to State or HCSSA policy.
October 2013	Added	K0510: Nutritional Approaches – Coding Tips	IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
October 2013	Removed	K0510: Nutritional Approaches – Coding Tips	Additives, such as electrolytes and insulin that are added to TPN or IV fluids—Code these in O0100H, IV Medication.
October 2013	Added	Coding Tips for K0510D	<ul style="list-style-type: none"> Therapeutic diets are not defined by the content of what is provided or when it is served, but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration Tips for K0510D
October 2013	Added	Coding Tips for K0510D, 2 nd bullet	(house supplement or packaged)
October 2013	Removed	Coding Tips for K0510D	<ul style="list-style-type: none"> K0510 (Nutritional Approaches) includes any and all nutrition and hydration received by the individual in the last 7 days either at their residence, at a hospital as an outpatient or as an inpatient, provided they were administered for nutrition or hydration.

Date	Action	Section	Change
October 2013	Replaced	K0700: percent Intake by Artificial Route	Replaced K0700: percent Intake by Artificial Route screenshot with updated one
October 2013	Removed	K0710A, Proportion of Total Calories the Individual Received through Parental or Tube Feedings ®	0
October 2013	Added	K0710A, Proportion of Total Calories the Individual Received through Parental or Tube Feedings ®	1
October 2013	Removed	K0710B, Average Fluid Intake per Day by IV or Tube Feeding ®	0
October 2013	Added	K0710B, Average Fluid Intake per Day by IV or Tube Feeding ®	1
October 2013	Added	L0200: Dental – Coding Tips, 1 st bullet	, in any items in which the coding requirements of Section J are met.
October 2013	Added	M0100: Determination of Pressure Ulcer/injury Risk –	START HERE
October 2013	Replaced	M0210: Unhealed Pressure Ulcer/injury(s)	Replaced M0210: Unhealed Pressure Ulcer/injury(s) screenshot with updated one

Date	Action	Section	Change
October 2013	Added	M0210: Unhealed Pressure Ulcer/injury(s) – Planning for Care	Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcer/injurs, lacerations, evulsions, etc.) A scab is evidence of wound healing. A pressure ulcer/injury that was staged as a 2 and now has a scab indicates it is a healing stage 2 and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab.
October 2013	Replaced	M0300A: Number of Stage 1 Pressure Ulcer/injurs ®	Replaced M0300A: Number of Stage 1 Pressure Ulcer/injurs screenshot with updated one
October 2013	Replaced	M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcer/injurs or Unstageable Pressure Ulcer/injury Due to Slough or Eschar	Replaced M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcer/injurs or Unstageable Pressure Ulcer/injury Due to Slough or Eschar screenshot with updated one
October 2013	Replaced	M0700: Most Severe Tissue Type for Any Pressure Ulcer/injury	Replaced M0700: Most Severe Tissue Type for Any Pressure Ulcer/injury screenshot with updated one
October 2013	Added	N0410: Medications Received - Health-related Quality of Life, 3 rd bullet	assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the individual's assessed condition.

Date	Action	Section	Change
October 2013	Removed	N0410: Medications Received - Health-related Quality of Life, 3rd bullet	reduce the need for or maximize the effectiveness of medications for all individuals. Therefore,
October 2013	Added	N0410: Medications Received - Coding Tips and Special Populations	herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document an individual's intake of herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the individual is currently taking.
October 2013	Replaced	O0400: Therapies (parts A and B)	Replaced O0400: Therapies screenshot with an updated one
October 2013	Replaced	O0400: Therapies (parts C and D)	Replaced O0400: Therapies screenshot with an updated one
October 2013	Added	S2. Claims Processing Information, (19.)	PW
October 2013	Removed	S2. Claims Processing Information, (19.)	STAR+PLUS
October 2013	Removed	S2e. Region	Arlington
October 2013	Added	S2e. Region	Grand Prairie
October 2013	Removed	S2f. Purpose Code – 1 st bullet	Or a Lookback

Date	Action	Section	Change
October 2013	Added	RUG Training - How to Complete and Submit an Assessment	TMHP receives a monthly feed of valid RN license numbers from the Texas Board of Nursing. Depending on dates, a nurse can renew the license timely, but if done close to the end of the expiration month, it could result in TMHP not receiving information of the renewal until the following month. In order to avoid this possibility, and ensure MN/LOC Assessments can be submitted on the TMHP LTC Online Portal, it is recommended that nurses renew their license a month prior to the expiration date.
October 2013	Replaced	Table of Contents	Replaced 0700 with 0710
October 2013	Added	C1600. Acute Onset of Mental Status Change	Code “-“ no information/not assessed Added updated screenshot and text.
October 2013	Removed	C1600. Acute Onset of Mental Status Change	If no caregiver or family member is available and there is no way to determine the individual’s baseline, code 0, No, and explain in S10, Comments.
October 2013	Removed	I0799b, I0899a, I0899b	Removed blood pressure reading fields, screenshots and text
October 2013	Replaced	K0700	Replaced all references of K0700 with K0710
October 2013	Added	O0400: Therapies	Added screenshot and text for co-treatment minutes: O0400A3A, O0400B3A, and O0400C3A
October 2013	Added	O0420 – Distinct Calendar Days of Therapy	Added screenshot and text for this new field
October 2013	Replaced	Appendix I – RUG Items - K0700	Replaced 0700 with 0710

Date	Action	Section	Change
October 2016	Deleted	Overview	All references to Community Based Alternative (CBA)
October 2016	Added	B0100 Comatose	Added coding tip
October 2016	Changed	C0500 Cognitive Patterns	Changed item label from "Summary Score" to "BIMS Summary Score"
October 2016	Changed	C0600: Should the Caregiver Assessment for Mental Status be Conducted?	Changed Options 0 and 1 from "complete interview" to "complete Brief Interview for Mental Status" Changed "Skip to C1300" to "Skip to C1310"
October 2016	Deleted	C1300 Signs and Symptoms of Delirium (from CAM©)	Replace with new Delirium item: C1310
October 2016	Added	C1310 Signs and Symptoms of Delirium (from CAM©)	New Delirium item: Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record Footnote: Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission
October 2016	Added	C1310A Acute onset Mental Status Change	New item: Is there evidence of an acute change in mental status from the individual's baseline? 0. No 1. Yes
October 2016	Added	C1310B-C1310D Inattention, Disorganized thinking, Altered level of consciousness	New items coding instructions: Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)
October 2016	Added	C1310B Inattention	New item: B. Did the individual have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?

Date	Action	Section	Change
October 2016	Added	C1310C Disorganized thinking	New item: Was the individual's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
October 2016	Added	C1310D Altered level of consciousness	New item: Did the individual have altered level of consciousness as indicated by any of the following criteria? * vigilant - startled easily to any sound or touch * lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch * stuporous - very difficult to arouse and keep aroused for the interview * comatose - could not be aroused
October 2016	Deleted	C1600 Acute Onset Mental Status change	Item deleted
October 2016	Added	I8000 Additional active diagnoses	Added to coding tips diagnoses codes prohibited from being entered.
October 2016	Changed	M0300G Unstageable- Deep tissue injury	Changed "Unstageable - Deep tissue" to "Unstageable - Deep tissue injury"
October 2016	Changed	M1040H Moisture Associated Skin Damage (MASD)	Changed "i.e. incontinence (IAD)" to "e.g., incontinence-associated dermatitis [IAD]".
October 2016	Changed	N0410 Medications Received	Changed instruction from "Indicate the number of DAYS the individual received the following medications during the last 7 days..." to "Indicate the number of DAYS the individual received the following medications by pharmacological classification, not how it is used, during the last 7 days..."
October 2016	Changed	N0410E Anticoagulant	Changed "warfarin" to "e.g., warfarin"
October 2017	Added	N0410H Opioid	New item
October 2017	Added	N0410 Medications Received	Added to coding tips diagnoses information related to new item: Opioid.
October 2017	Changed	Section P	Updated Intent section to reflect addition of "Alarms."

Date	Action	Section	Change
October 2017	Added	P0200 Alarms	New item
October 2018	Added	J2000: Prior Surgery	New Item: This item identifies whether an individual has had major surgery during the 100 days prior to this assessment. A recent history of major surgery can affect an individual's care and recovery.
October 2018	Changed	Section M Intro Note	Added the word "Injury" after ulcer
October 2018	Changed	M0100	Added the word "Injury" after ulcer
October 2018	Changed	M100A	Added the word "Injury" after ulcer
October 2018	Changed	M0150	Added the word "Injury" after ulcer
October 2018	Changed	M0210	Added the word "Injury" after ulcer
October 2018	Changed	M0300	Added the word "Injury" after ulcer
October 2018	Changed	M0300A	Added the word "Injury" after ulcer
October 2018	Deleted	M0300B3	Deleted
October 2018	Changed	M0300D1	Added the word "Injury" after ulcer
October 2018	Changed	M0300E	Added the word "Injury" after ulcer
October 2018	Changed	M0300G	Added the word "Injury" after ulcer
October 2018	Deleted	M0610	Deleted
October 2018	Deleted	M0700	Deleted
October 2018	Changed	M1200	Added the word "Injury" after ulcer
October 2018	Changed	M1200E	Added the word "Injury" after ulcer
October 2018	Changed	O0100F	Invasive Mechanical Ventilator
October 2018	Changed	O0100G	Non-invasive Mechanical Ventilator (BiPAP / CPAP)
July 2019	Changed	E0900	Changed "Behavioral" to "Behavior" in skip pattern wording
July 2019	Changed	E1100	Changed "Behavioral" to "Behavior"

Date	Action	Section	Change
July 2019	Changed	I5900	Changed text to “I5900, bipolar disorder from manic depression (bipolar disease)”
July 2019	Deleted	D0350	Item and instructions removed
July 2019	Deleted	D0650	Item and instructions removed