# RAI MDS 3.0 Manual Updates
# Part 1
# August 18th, 2016

Texas Medicaid Coalition
SimpleLTC
RELIAS LEARNING

## PRESENTER

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- Senior Analyst: SNF Regulations and Clinical Reimbursement

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## Handouts

- PPT presentation
- New PPS Part A Discharge Assessment item set
- Discharge Assessment Flowchart



## Objectives

- Introduce learners to new Discharge assessment requirements.
- Discuss changes to Section C
- Discuss coding guidance changes to Section J
- Discuss coding guidance changes to Section M
- Discuss other minor revisions/clarifications.

## Disclaimer

- RAI Manual Update was issued in **DRAFT** format.
- Close review finds potential issues/conflicts with current coding scenarios related to new discharge assessments.
- Questions arise to coding of A0310G and A2000 as they pertain to the new End of Medicare Discharge Assessment.
- Today's training will focus on overall requirements related to new discharge assessments as well as other coding changes/clarifications (except Section GG).
- Please review final manual when released for updates/corrections/clarifications.



## Discharge Assessments

- New Discharge item set being introduced 10/1/2016
  - Part A PPS Discharge (NPE) Item Set
- Required as part of new SNF Quality Reporting Program
  - Required to collection information at start of Medicare stay and end of Medicare stay
  - Currently no mechanism to collect information at end of Medicare stay.
- Part A PPS Discharge (NPE) Item Set
  - Includes 5 sections (A, GG, J and M and X).
  - Allows for collection of clinical data for the 3 QRP QMs.
    - Pressure Ulcers
    - Falls w/ Major Injury
    - Assessment of Functional Status

## Discharge Assessments

- Discharge assessments are required on residents discharged from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility.

- Will now be categorized into two types
  - OBRA – required when resident is discharged from the facility.
    - Discharge Return Anticipated
    - Discharge Return Not Anticipated
  - End of Medicare Stay – Medicare Part A stay ends.

**Some situations will require coding of both types of discharges!**



## Discharge Assessments

### Part A PPS Discharge Assessment (A0310H)


The SNF Part A PPS Discharge Assessment required under 2 possible circumstances:

**Scenario 1**

1. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility).

## Discharge Assessments

### Standalone Part A PPS Discharge Assessment (A0310H =1)

The ARD (Item A2300) for the Part A PPS Discharge assessment is always equal to the End Date of Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay [A2400C] + 14 calendar days).



## Discharge Assessments

### Standalone Part A PPS Discharge Assessment (A0310H =1)

Mrs. K was under a Medicare Part A stay from 10/4/16 thru 12/17/16. Mrs. K will remain in the facility under some other payer source receiving LTC services.

- A0310F = 99
- A0310G = ^
- A0310H = 1, End of Medicare Discharge Assessment
- A2300 = 12/17/16
- A2400C = 12/17/16

**Only a Part A PPS Discharge Assessment would be completed**.

## Discharge Assessments

### Part A PPS Discharge Assessment (A0310H)


The SNF Part A PPS Discharge Assessment required under 2 possible circumstances:

**Scenario 2**

If the Medicare Part A stay ends **on the day of or one day before** the date of physical discharge, the OBRA Discharge assessment and PPS Part A Discharge assessment are **both required and may be combined**.



## Discharge Assessments

**OBRA Discharge Combine w/ Part A PPS Discharge Assessment**

If the End Date of Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

## Discharge Assessments

### OBRA Discharge and Part A PPS Discharge Assessment Example

Mrs. G is receiving skilled services under a Part A stay beginning 10/14/16. It is determined she no longer needs skilled services and a NOMNC is issued indicating the last covered day of Medicare coverage is 11/23/16. She discharges from the facility on 11/24/16.

- A0310F = 10, Discharge Return not anticipated
- A0310G =1 , planned discharge
- A0310H = 1, Yes, end of Medicare Stay assessment
- A2000 – 11/24/16 Discharge date
- A2300 – 11/24/16 ARD
- A2400C – 11/23/16

**Both types of discharge assessments required. May be combined since Medicare stay ended 1 day before facility discharge.**



## Discharge Assessments

### Part A PPS Discharge Assessment Example

- Mr. W. began his Medicare Part A stay on 11/15/16 and ended on 11/25/16. He was unexpectedly discharged to the hospital on 11/26/16 and is expected to return.
  - A0310F = 11, Discharge return anticipated
  - A0310G = 2 , unplanned discharge
  - A0310H = 1, Yes, Part A PPS Discharge Assessment
  - A2000 – 11/26/16 Discharge date
  - A2300 – 11/26/16 ARD
  - A2400C – 11/25/16

## Discharge Assessments

### Part A PPS Discharge Assessment (A0310H)
### A2400C Instruction Revisions

- If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the same day that the resident dies, a Death in Facility Tracking Record is completed, with the Discharged Date (A2000) equal to the date the resident died. **A Part A PPS Discharge assessment is not required.**

- No discharge assessments required. Same as current practice.



## Discharge Assessments

### Part A PPS Discharge Assessment (A0310H)
### Combining Assessments

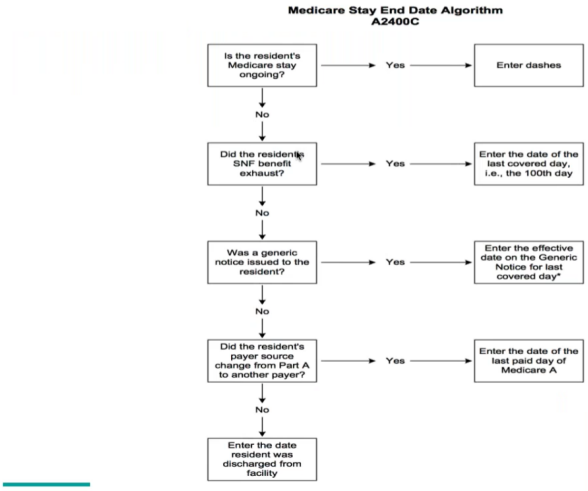
The Medicare Part A PPS Discharge Assessment may be combined with other assessments. The DRAFT RAI manual provides coding guidance and instructions for the following:

- Medicare-required Scheduled Assessment and Part A PPS Discharge Assessment
- Start of Therapy OMRA and Part A PPS Discharge Assessment
- End of Therapy OMRA and Part A PPS Discharge Assessment
- Start and End of Therapy OMRA and Part A PPS Discharge Assessment
- Change of Therapy OMRA and Part A PPS Discharge Assessment

**Review FINAL RAI Manual for any Revisions**

## Discharge Assessments

### Review Coding Instructions for A2400C

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## Discharge Assessments

### Planned vs. Unplanned Discharge (A03010G)

An unplanned discharge includes, for example:

- Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
- Resident unexpectedly leaving the facility against medical advice; or
- Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).

**Chapter 2, p 2-39**

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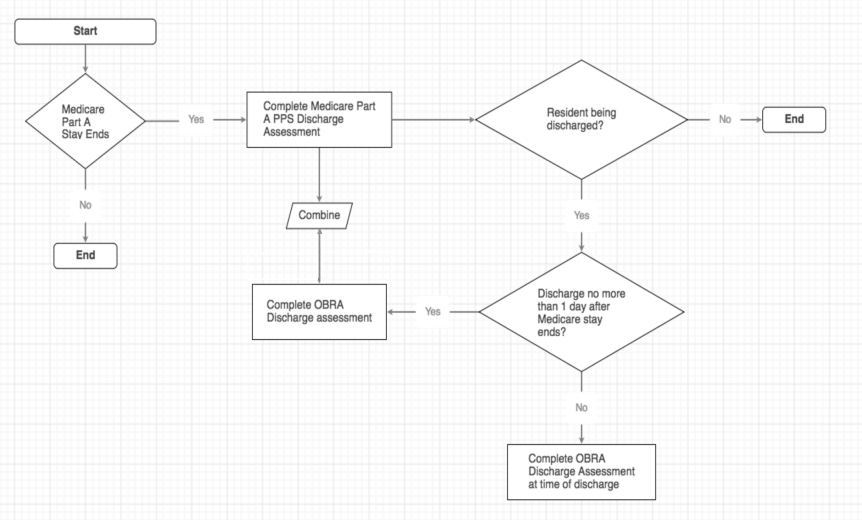
## Discharge Assessments






## General Coding Guidance Clarification

- When determining the response to items that have a look-back period to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, staff must only consider those assessments that are required to be submitted to the QIES ASAP system. PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to the QIES ASAP system and therefore should not be considered when determining the "prior assessment". (Chapter 3, Page 3-3)

**J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent**

Enter Code ☐

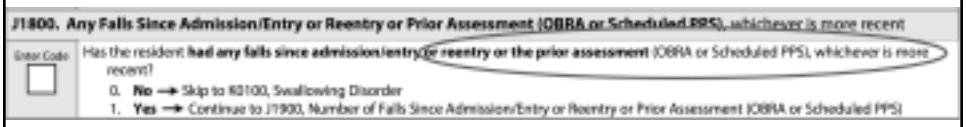
Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?

0. **No** → Skip to J3100, Swallowing Disorder
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

## General Coding Guidance Clarification

Example:

Resident is a Medicare Advantage resident.
- 5-day assessment completed
- OBRA Admission assessment completed
- 14-day assessment completed
- 30-day assessment completed
- 60-day assessment completed
- 90-day assessment completed
- Quarterly assessment currently in process.


J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code

Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent?
0. No → Skip to J2100, Swallowing Disorder
1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)



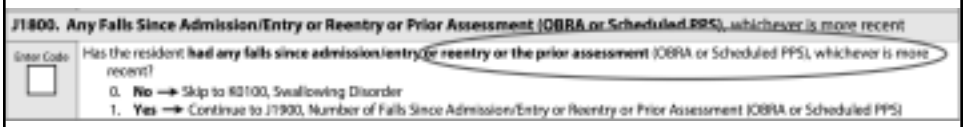
## General Coding Guidance Clarification

Example:

Resident is a Medicare Advantage resident.
- 5-day assessment completed - not submitted
- OBRA Admission assessment completed
- 14-day assessment completed
- 30-day assessment completed
- 60-day assessment completed
- 90-day assessment completed

} Not Submitted

- Quarterly Assessment currently in process.


J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code

Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent?
0. No → Skip to J2100, Swallowing Disorder
1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

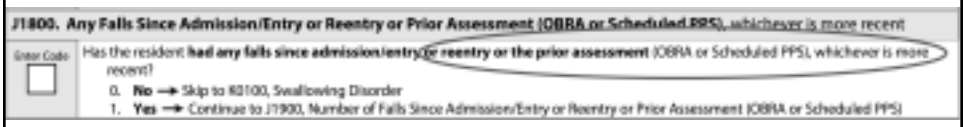
## General Coding Guidance Clarification

Example:

Resident is a Medicare Advantage resident.

- ~~5-day assessment completed~~
- OBRA Admission assessment completed
- ~~14-day assessment completed~~
- ~~30-day assessment completed~~
- ~~60-day assessment completed~~
- ~~90-day assessment completed~~
- Quarterly Assessment currently in process.

**Prior Assessment (OBRA)**


J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code ☐ Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?

0. **No** → Skip to J2100, Swallowing Disorder
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

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## Section A

**A0310 E**

**Is this assessment the first assessment (OBRA, Scheduled PPS, or OBRA Discharge) since the most recent admission/entry or reentry?**

Code 0, No – Entry or Death in Facility Records

**A standalone Part A PPS Discharge assessment**

A standalone unscheduled PPS Assessment


Enter Code ☐ E. **Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**

0. **No**
1. **Yes**

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## Section C

**C0900**

- Added “hospital swing bed” to D.

| C0900. Memory/Recall Ability | |
|---|---|
| ↓ Check all that the resident was normally able to recall | |
| ☐ | A. Current season |
| ☐ | B. Location of own room |
| ☐ | C. Staff names and faces |
| ☐ | D. That he or she is in a nursing home/hospital swing bed |
| ☐ | Z. None of the above were recalled |



## Section C

- Changes made to formatting of the Confusion Assessment Method (CAM).
- Combined C1300 and C1600
- Removed Psychomotor Retardation
- Changed C1300 to C1310

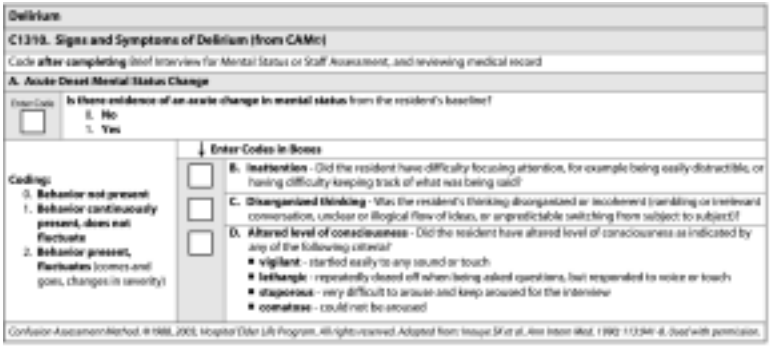
**Old**

| Delirium | | |
|---|---|---|
| C1300. Signs and Symptoms of Delirium (From CAM®) | | |
| Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record | | |
| Coding:<br>0. **Behavior not present**<br>1. **Behavior continuously present, does not fluctuate**<br>2. **Behavior present, fluctuates** (comes and goes, changes in severity) | ↓ Enter Codes in Boxes | |
| | ☐ | A. **Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)? |
| | ☐ | B. **Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? |
| | ☐ | C. **Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **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)? |
| | ☐ | D. **Psychomotor retardation** - Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly? |
| C1600. Acute Onset Mental Status Change | | |
| Enter Code ☐ | Is there evidence of an acute change in mental status from the resident's baseline?<br>0. **No**<br>1. **Yes** | |

## Section C

- Changes made to formatting of the Confusion Assessment Method (CAM).
- Combined C1300 and C1600
- Removed Psychomotor Retardation
- Changed C1300 to C1310

**New**



**Delirium**

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

Code **after completing** brief interview for Mental Status or Staff Assessment, and reviewing medical record

**A. Acute Onset Mental Status Change**

**Is there evidence of an acute change in mental status** from the resident's baseline?
0. **No**
1. **Yes**

↓ **Enter Codes in Boxes**

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

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

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

**D. Altered level of consciousness** - Did the resident have altered level of consciousness as indicated by any of the following criteria?
- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly closed 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.



## Section F

- One small clarification
- Under Steps for the Assessment (page F-1)
  - Added information related to when the assessments should be completed.
  - **Conduct the interview during the observation period.**
- Also, under Coding Tips and Special Populations (page F-5)
  - No look-back is provided for resident. He or she is being asked about current preferences while in the nursing home but is not limited to a 7-day look-back period to convey what his/her preferences are.
  - **The facility is still obligated to complete the interview within the 7-day lookback period.**

## Section J

**J1800 – J1900**

- CMS providing clarification instructions to ensure accuracy of these items
- These items do impact the Quality Reporting Program (QRP) QM on Falls w/ Major Injury.
- Facilities had been cited on this or at least questioned coding on this particular issue during an MDS Focused Survey.



## Section J

**J1900 (Page J-31)**

Planning for Care

- It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look-back of the MDS.

## Section J

**J1900 (Page J-32)**

Steps for Assessment

6. Review any follow-up medical information received pertaining to the fall, **even if this information is received after the ARD** (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.



## Section J

**J1900 (Page J-33)**

- Coding Tip
  - If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.
  - See example in manual, page J-34
  - Would also apply to modification of discharge assessments.

## Section M

**Clarified/Changed coding related to "Present on Admission" (Page M-7)**

5. If a resident who has a pressure ulcer that was originally acquired in the facility is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer should not be coded as "present on admission" because it was present and acquired at the facility prior to the hospitalization.



## Section M

**Clarified/Changed coding related to "Present on Admission" (Page M-7)**

6. If a resident who has a pressure ulcer that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is still coded as "present on admission" because it was originally acquired outside the facility and has not changed in stage.

## Section M

**Clarified/Changed coding related to "Present on Admission" (Page M-7)**

7. If a resident who has a pressure ulcer is hospitalized and the ulcer increases in numerical stage during the hospitalization, it should be coded as "present on admission" at that higher stage upon reentry.

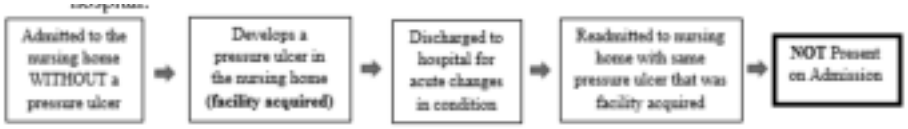


## Section M

Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as "**present on admission**" as it was **not acquired in the facility**. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered "present on admission"** because it was **originally acquired outside the facility** and has not changed.

## Section M

Ms. K is admitted to the facility without a pressure ulcer. During the stay, she develops a stage 2 pressure ulcer. This is a **facility acquired** pressure ulcer and was **not "present on admission."** Ms. K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home** and **should not be considered as "present on admission"** when she returns from the hospital.






## Other "minor" clarifications

- Section N – Code medications according to the pharmacological classification, not how they are being used.
- Section N – updated drug resources and web sites.
- Section O – Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.
- Made revisions to the Delirium CAA information in Chapter 4 due to changes in Section C.
- Section Q, some wording revisions in Q0490 and Q0550.

## Section GG

- Section GG will be covered in our RAI Manual Updates Part 2.
- September 16th, 2016 11am – 12:30 CT
- Will discuss coding and any updates from CMS training.



## Resources

- RAI Manual Draft Version 1.14 May 2016

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html


ais
Assessment &
Intelligence Systems
is now part of
RELIAS LEARNING



**THANK YOU**

Resident _____ Identifier _____ Date _____

# MINIMUM DATA SET (MDS) - Version 3.0
## RESIDENT ASSESSMENT AND CARE SCREENING
### *Nursing Home Part A PPS Discharge (NPE) Item Set*

## Section A Identification Information

### A0050. Type of Record

Enter Code

1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

### A0100. Facility Provider Numbers

**A. National Provider Identifier (NPI):**

**B. CMS Certification Number (CCN):**

**C. State Provider Number:**

### A0200. Type of Provider

Enter Code

**Type of provider**
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

### A0310. Type of Assessment

Enter Code

**A. Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code

**B. PPS Assessment**
**PPS Scheduled Assessments for a Medicare Part A Stay**
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
**PPS Unscheduled Assessments for a Medicare Part A Stay**
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
**Not PPS Assessment**
99. **None of the above**

Enter Code

**C. PPS Other Medicare Required Assessment - OMRA**
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment

Enter Code

**D. Is this a Swing Bed clinical change assessment?** Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

**E. Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
0. **No**
1. **Yes**

**A0310 continued on next page**

# Section A Identification Information

## A0310. Type of Assessment - Continued

Enter Code

**F. Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

Enter Code

**G. Type of discharge** - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

Enter Code

**H. Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

## A0410. Unit Certification or Licensure Designation

Enter Code

1. **Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
2. **Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
3. **Unit is Medicare and/or Medicaid certified**

## A0500. Legal Name of Resident

**A. First name:** **B. Middle initial:**

**C. Last name:** **D. Suffix:**

## A0600. Social Security and Medicare Numbers

**A. Social Security Number:**

_ _

**B. Medicare number** (or comparable railroad insurance number)**:**

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

## A0800. Gender

Enter Code

1. **Male**
2. **Female**

## A0900. Birth Date

_ _

Month Day Year

## A1000. Race/Ethnicity

**Check all that apply**

- ☐ **A. American Indian or Alaska Native**
- ☐ **B. Asian**
- ☐ **C. Black or African American**
- ☐ **D. Hispanic or Latino**
- ☐ **E. Native Hawaiian or Other Pacific Islander**
- ☐ **F. White**

# Section A Identification Information

## A1100. Language

Enter Code

**A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?**

0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

**B. Preferred language:**

## A1200. Marital Status

Enter Code

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

## A1300. Optional Resident Items

**A. Medical record number:**

**B. Room number:**

**C. Name by which resident prefers to be addressed:**

**D. Lifetime occupation(s)** - put "/" between two occupations**:**

## Most Recent Admission/Entry or Reentry into this Facility

## A1600. Entry Date

__ __

Month Day Year

## A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

## A1800. Entered From

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

## Section A Identification Information

### A1900. Admission Date (Date this episode of care in this facility began)

_ _
Month Day Year

### A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

_ _
Month Day Year

### A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

### A2300. Assessment Reference Date

**Observation end date:**

_ _
Month Day Year

### A2400. Medicare Stay

Enter Code

**A. Has the resident had a Medicare-covered stay since the most recent entry?**

0. **No** → Skip to GG0130, Self-Care
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

**B. Start date of most recent Medicare stay:**

_ _
Month Day Year

**C. End date of most recent Medicare stay** - Enter dashes if stay is ongoing:

_ _
Month Day Year

## Section GG | Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

**GG0130. Self-Care** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)

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

**Coding:**

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

*Activities may be completed with or without assistive devices.*

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

**If activity was not attempted, code reason:**

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

| 3. Discharge Performance | |
|---|---|
| Enter Code | **A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/ tray. Includes modified food consistency. |
| Enter Code | **B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] |
| Enter Code | **C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment. |

## Section GG | Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

**GG0170. Mobility** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)

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

**Coding:**

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

*Activities may be completed with or without assistive devices.*

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

**If activity was not attempted, code reason:**

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

| **3. Discharge Performance**<br>**Enter Codes in Boxes** | |
|---|---|
| | **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed. |
| | **C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. |
| | **D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed. |
| | **E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair). |
| | **F. Toilet transfer:** The ability to safely get on and off a toilet or commode. |
| | **H3. Does the resident walk?**<br>0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter?<br>2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns |
| | **J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns. |
| | **K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. |
| | **Q3. Does the resident use a wheelchair/scooter?**<br>0. **No** → Skip to J1800, Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent<br>1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns |
| | **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns. |
| | **RR3. Indicate the type of wheelchair/scooter used.**<br>1. **Manual**<br>2. **Motorized** |
| | **S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space. |
| | **SS3. Indicate the type of wheelchair/scooter used.**<br>1. **Manual**<br>2. **Motorized** |

## Section J Health Conditions

**J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS),** whichever is more recent

Enter Code

Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?

0. **No** → Skip to M0210, Unhealed Pressure Ulcer(s)
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

**J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS),** whichever is more recent

**Coding:**
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

## Section M Skin Conditions

**Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage**

**M0210. Unhealed Pressure Ulcer(s)**

Enter Code

**Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**

0. **No** → Skip to Z0400, Signature of Persons Completing the Assessment or Entry/Death Reporting
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage**

**B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number

**1. Number of Stage 2 pressure ulcers -** If 0 → Skip to M0300C, Stage 3

Enter Number

**2. Number of <u>these</u> 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

**C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number

**1. Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number

**2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

**D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number

**1. Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing

Enter Number

**2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

**M0300 continued on next page**

## Section M Skin Conditions

**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** - Continued

**E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device

Enter Number

1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar

Enter Number

2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

**F. Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable - Deep tissue injury

Enter Number

2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution

Enter Number

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0800, Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry

Enter Number

2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry**
Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last admission/entry or reentry. If no current pressure ulcer at a given stage, enter 0

Enter Number

**A. Stage 2**

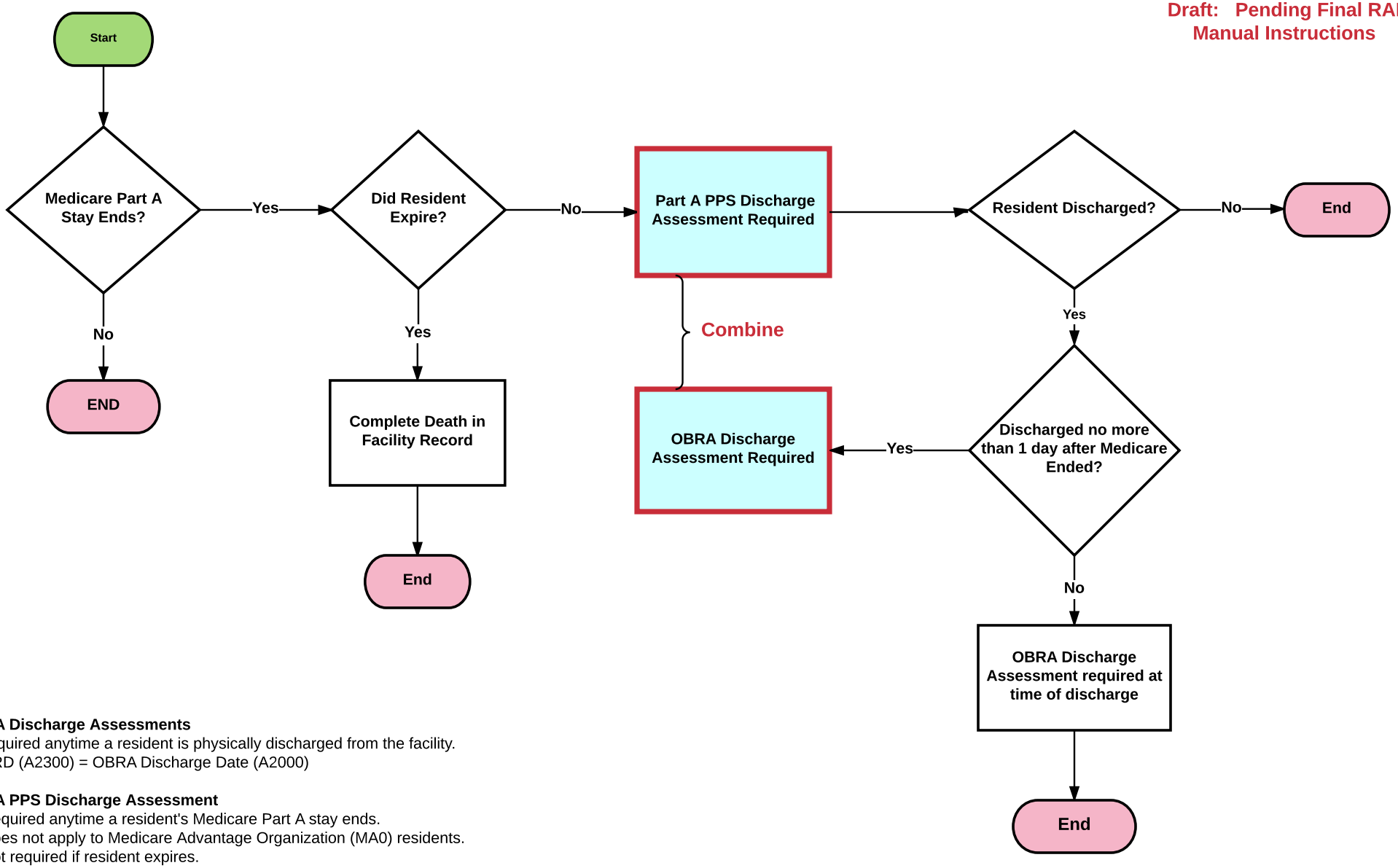
Enter Number

**B. Stage 3**

Enter Number

**C. Stage 4**

Draft: Pending Final RAI Manual Instructions




**OBRA Discharge Assessments**
1. Required anytime a resident is physically discharged from the facility.
2. ARD (A2300) = OBRA Discharge Date (A2000)

**Part A PPS Discharge Assessment**
1. Required anytime a resident's Medicare Part A stay ends.
2. Does not apply to Medicare Advantage Organization (MA0) residents.
3. Not required if resident expires.
4. ARD (A2300) = Last Covered Medicare Stay Date (A2400C)

**Combined OBRA DIscharge Assessment/Part A PPS Discharge Assessment**
1. Both assessments may be combined if the following criteria met:
    a. Medicare Part A stay ends; AND
    b. Resident is phsically discharged from the facility wihtin 1 day of last covered Medicare day (A2400c)
2. ARD (A2300) = OBRA DIscharge Date (A2000)

# Medicare Part A MDS Discharge Assessments

**(Effective 10/1/2016)**