

If it's not documented, it's not done!

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Participants will be able to:

- Describe 3 critical elements of excellent medical record documentation
- State 3 adverse consequences of improper or missing documentation
- Discuss 4 key components related to PDPM documentation



In God we trust

All others must document

Purpose of Documentation

AHIMA* says there are 5 purposes for documentation:

1. Basis for planning and treatment
2. Means of communication for attending health professionals
3. Legal entries describe the care the patient receives
4. Verification of services for payers
5. Provides basic data for health research

*American Health Information Management Association
<https://www.ahima.org/>

Documentation Supports

- Services provided and the resident's response
- Assessment of resident condition and needs
- Interventions to meet resident needs
- Person-centered and comprehensive care plan
- Effectiveness of treatment, education, training and services/interventions
- Administration of medications and treatments
- Interactions with residents, families, physicians and other healthcare personnel
- Reimbursement from Federal and State programs as well as other third party payors
- Survey process
- Quality measures/QRPs

Documentation Includes...

- Medical Record – Paper and Electronic
- MDS 3.0 – RAI Process
- Progress Notes
- Baseline Care Plan
- Baseline Care Plan Summary
- Comprehensive Care Plan
- ICD-10 Diagnosis(es)
- Interdisciplinary Notes
- Physician Orders
- MARS and TARS
- Physician Certification/Recertification
- Beneficiary Notices
- Triple Check
- Restorative Nursing
- Facility Assessment
- Discharge Summary



Regulatory Language – F842

The medical record shall reflect a resident's progress toward achieving their person-centered plan of care objectives and goals and the improvement and maintenance of their clinical, functional, mental and psychosocial status. Staff must document a resident's medical and non-medical status when any positive or negative condition change occurs, at a periodic reassessment and during the annual comprehensive assessment. The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team.

The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions.

F842

§483.70(i) Medical records.
§483.70(i)(1) In accordance with **accepted professional standards and practices**, the facility must maintain medical records on each resident that are— (i) **Complete**; (ii) **Accurately documented**; (iii) **Readily accessible**; and (iv) **Systematically organized**

§483.70(i)(5) The medical record must contain— (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician, nurse, and other licensed professionals progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

30.2.2.1 – Documentation to Support Skilled Care Determinations

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—

- Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
- The services themselves are, in fact, **reasonable and necessary** for the treatment of a patient’s illness or injury, i.e., are **consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice**. The documentation must also show that the services are appropriate in terms of duration and quality, and that the services promote the documented therapeutic goals.

Chapter 8 – Medicare Benefit Policy Manual

30.6 - Daily Skilled Services Defined

(Rev. 249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a “daily basis,” i.e., on essentially a 7-days-a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the “daily” requirement would not be met.)

It is expected that the **documentation in the patient's medical record will reflect the need for the skilled services provided.** The patient's medical record is also expected to provide important communication among all members of the care team regarding the **development, course, and outcomes of the skilled observations, assessments, treatment, and training performed.**

Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the **documentation will serve to demonstrate why a skilled service is needed.**

Patient's Medical Record Must Document...

- History and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services);
- Skilled services provided;
- Patient's response to the skilled services provided during the current visit;
- Plan for future care based on the rationale of prior results;
- Detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;
- Complexity of the service to be performed;
- Any other pertinent characteristics of the beneficiary.

The documentation in the patient's medical record must be accurate, and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care.

When Documentation is Missing/Inadequate...



Potential legal consequences for clinician/practitioner

- Subpoenas/depositions/testify in court if lawsuit filed
- Loss of professional license
- Investigation by State and/or Federal surveyors
- Fines
- Loss of freedom, including incarceration
- Unwanted/negative publicity
- Placement on OIG exclusion list

Potential legal consequences for facility/provider

- Subpoenas/depositions/testify in court if lawsuit filed
- Investigation by State and/or Federal surveyors
- Deficiency(ies) with potential CMPs
- Possible exclusion from admitting Medicare/Medicaid beneficiaries
- Loss of license
- Loss of freedom, including incarceration
- Unwanted/negative publicity
- Placement on OIG exclusion list

Financial Consequences of Missing/Inadequate Documentation...



- Less than optimal reimbursement for care provided
- No reimbursement for care provided – provider liability
- Need to repay monies received
- **Denial of claim**
- TPE (Targeted Probe & Educate) audit
- Other audits
 - RAC (Recovery Audit Contractor)
 - MAC (Medicare Administrative Contractor)
 - ZPIC (Zone Program Integrity Contractor)
 - CERT (Comprehensive Error Rate Testing)

Physician Certification and Recertification of Extended Care Services

- Payment for covered posthospital extended care services may be made **only** if a physician or a physician extender) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished.
- A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner, a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

And...

- The certification must clearly indicate that **posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a continuing basis for any of the conditions for which he/she was receiving inpatient hospital services, including services of an emergency hospital (see Chapter 5, §20.2) prior to transfer to the SNF. Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable.** The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.
- If ambulance service is furnished by a skilled nursing facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case, including the physician who requested the ambulance or the physician who examined the patient upon his arrival at the facility. **The physician must certify that the ambulance service was medically required.**

Timing of Recertifications

The **first recertification must be made no later than the 14th day** of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories. **Subsequent recertifications must be made at intervals not exceeding 30 days.**

Days = calendar days

Recertifications

- Must state the reason for continued skilled services – why needed
- Must state the projected time frame
- Must state the post-SNF plans
- Must be timely
- Must be signed and dated to validate timely oversight

MDS Requirements

OBRA-Required Tracking Records and Assessments

Tracking records:

- Entry
- Death in facility

Assessments:

- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- SCQA
- Discharge (return not anticipated or return anticipated)

PPS Assessments

- 5-Day/Initial Medicare Assessment
- Interim Payment Assessment (IPA) - Optional
- Part A PPS Discharge Assessment (NPE)

Section I – Active Diagnoses (Primary Reason for Admission)

Section I		Active Diagnoses	
I0020. Indicate the resident's primary medical condition category Complete only if A0310B = 01 or 08			
Enter Code <input type="text"/> <input type="text"/>	Indicate the resident's primary medical condition category that best describes the primary reason for admission		
	<ul style="list-style-type: none">01. <input type="checkbox"/> Stroke02. <input type="checkbox"/> Non-Traumatic Brain Dysfunction03. <input type="checkbox"/> Traumatic Brain Dysfunction04. <input type="checkbox"/> Non-Traumatic Spinal Cord Dysfunction05. <input type="checkbox"/> Traumatic Spinal Cord Dysfunction06. <input type="checkbox"/> Progressive Neurological Conditions07. <input type="checkbox"/> Other Neurological Conditions08. <input type="checkbox"/> Amputation09. <input type="checkbox"/> Hip and Knee Replacement10. <input type="checkbox"/> Fractures and Other Multiple Trauma11. <input type="checkbox"/> Other Orthopedic Conditions12. <input type="checkbox"/> Debility, Cardiorespiratory Conditions13. <input type="checkbox"/> Medically Complex Conditions		
I0020B. ICD Code		<input type="text"/>	
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html			



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"/>	10100. Cancer (with or without metastasis)
Heart/Circulation	
<input type="checkbox"/>	10200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	10300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias, tachycardias)
<input type="checkbox"/>	10400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	10500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	10600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	10700. Hypertension
<input type="checkbox"/>	10800. Orthostatic Hypotension
<input type="checkbox"/>	10900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) (2) (3)
Gastrointestinal	
<input type="checkbox"/>	11100. Cirrhosis
<input type="checkbox"/>	11200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	11300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
Genitourinary	
<input type="checkbox"/>	11400. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/>	11500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
<input type="checkbox"/>	11550. Neurogenic Bladder
<input type="checkbox"/>	11650. Obstructive Uropathy
Infections (CA)	
<input type="checkbox"/>	11700. Multidrug-Resistant Organism (MDRO) (2) - (3)
<input type="checkbox"/>	12000. Pneumonia (2) - (3)
<input type="checkbox"/>	12100. Septicemia (2) - (3)
<input type="checkbox"/>	12200. Tuberculosis (2) - (3)
<input type="checkbox"/>	12300. Urinary Tract Infection (UTI) (LAST 30 DAYS) (2) - (3) (4)
<input type="checkbox"/>	12400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) (2) - (3)
<input type="checkbox"/>	12500. Wound Infection (other than foot) (2) - (3)
Metabolic	
<input type="checkbox"/>	12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy) (2) (3)
<input type="checkbox"/>	13100. Hyponatremia
<input type="checkbox"/>	13200. Hyperkalemia
<input type="checkbox"/>	13300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	13400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
Musculoskeletal	
<input type="checkbox"/>	13700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
<input type="checkbox"/>	13800. Osteoporosis
<input type="checkbox"/>	13900. 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"/>	14000. Other Fracture
Neurological (CA)	
<input type="checkbox"/>	14200. Alzheimer's Disease (2) - (3) (4)
<input type="checkbox"/>	14300. Aphasia
<input type="checkbox"/>	14400. Cerebral Palsy
<input type="checkbox"/>	14500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	14800. 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) (2) - (3)
Neurological Diagnoses continued on next page	

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	
Neurological – Continued	
<input type="checkbox"/>	14900. Hemiplegia or Hemiparesis
<input type="checkbox"/>	15000. Paraplegia
<input type="checkbox"/>	15100. Quadriplegia
<input type="checkbox"/>	15200. Multiple Sclerosis (MS)
<input type="checkbox"/>	15250. Huntington's Disease
<input type="checkbox"/>	15300. Parkinson's Disease
<input type="checkbox"/>	15350. Tourette's Syndrome
<input type="checkbox"/>	15400. Seizure Disorder or Epilepsy
<input type="checkbox"/>	15500. Traumatic Brain Injury (TBI)
Nutritional	
<input type="checkbox"/>	15600. Malnutrition (protein or calorie) or at risk for malnutrition (1)
Psychiatric/Mood Disorder	
<input type="checkbox"/>	15700. Anxiety Disorder
<input type="checkbox"/>	15800. Depression (other than bipolar)
<input type="checkbox"/>	15900. Bipolar Disorder
<input type="checkbox"/>	15950. Psychotic Disorder (other than schizophrenia)
<input type="checkbox"/>	16000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)
<input type="checkbox"/>	16100. Post Traumatic Stress Disorder (PTSD)
Pulmonary	
<input type="checkbox"/>	16200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
<input type="checkbox"/>	16300. Respiratory Failure
Vision (CA)	
<input type="checkbox"/>	16500. Cataracts, Glaucoma, or Macular Degeneration (2) - (3)
None of Above	
<input type="checkbox"/>	17900. None of the above active diagnoses within the last 7 days
Other http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNPPSPDPM.html	
18000. Additional active diagnoses	
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.	
<input type="checkbox"/> A.	<input type="text"/>
<input type="checkbox"/> B.	<input type="text"/>
<input type="checkbox"/> C.	<input type="text"/>
<input type="checkbox"/> D.	<input type="text"/>
<input type="checkbox"/> E.	<input type="text"/>
<input type="checkbox"/> F.	<input type="text"/>
<input type="checkbox"/> G.	<input type="text"/>
<input type="checkbox"/> H.	<input type="text"/>
<input type="checkbox"/> I.	<input type="text"/>
<input type="checkbox"/> J.	<input type="text"/>

Diagnoses

- **Physician-documented diagnoses** in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
- Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Section J – Health Conditions: Surgical Procedures

Surgical Procedures – Complete only if J2100 = 1	
↓ Check all that apply	
Major Joint Replacement	
<input type="checkbox"/>	J2300. Knee Replacement - partial or total
<input type="checkbox"/>	J2310. Hip Replacement - partial or total
<input type="checkbox"/>	J2320. Ankle Replacement - partial or total
<input type="checkbox"/>	J2330. Shoulder Replacement - partial or total
Spinal Surgery	
<input type="checkbox"/>	J2400. Involving the spinal cord or major spinal nerves
<input type="checkbox"/>	J2410. Involving fusion of spinal bones
<input type="checkbox"/>	J2420. Involving lamina, discs, or facets
<input type="checkbox"/>	J2499. Other major spinal surgery
Other Orthopedic Surgery	
<input type="checkbox"/>	J2500. Repair fractures of the shoulder - (including clavicle and scapula) or arm (but not hand)
<input type="checkbox"/>	J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)
<input type="checkbox"/>	J2520. Repair but not replace joints
<input type="checkbox"/>	J2530. Repair other bones (such as hand, foot, jaw)
<input type="checkbox"/>	J2599. Other major orthopedic surgery
Neurological Surgery	
<input type="checkbox"/>	J2600. Involving the brain, surrounding tissue or blood vessels (excludes skull and skin but includes cranial nerves)
<input type="checkbox"/>	J2610. Involving the peripheral or automatic nervous system - open or percutaneous
<input type="checkbox"/>	J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices
<input type="checkbox"/>	J2699. Other major neurological surgery
Cardiopulmonary Surgery	
<input type="checkbox"/>	J2700. Involving the heart or major blood vessels - open or percutaneous procedures
<input type="checkbox"/>	J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open or endoscopic
<input type="checkbox"/>	J2799. Other major cardiopulmonary surgery
Genitourinary Surgery	
<input type="checkbox"/>	J2800. Involving male or female organs (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
<input type="checkbox"/>	J2810. Involving the kidneys, ureters, adrenal glands, or bladder - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
<input type="checkbox"/>	J2899. Other major genitourinary surgery
Other Major Surgery	
<input type="checkbox"/>	J2900. Involving tendons, ligaments, or muscles
<input type="checkbox"/>	J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
<input type="checkbox"/>	J2920. Involving the endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, or thymus - open
<input type="checkbox"/>	J2930. Involving the breast
<input type="checkbox"/>	J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant
<input type="checkbox"/>	J5000. Other major surgery not listed above

Surgical Procedures Documentation

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08	
Enter Code <input type="checkbox"/>	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. <input type="radio"/> No 1. <input type="radio"/> Yes 8. <input type="radio"/> Unknown

- Work with transferring acute facility to obtain documentation of surgical procedures at admission
- Contact transferring acute facility to obtain this documentation if not received at admission
- Surgery information, including past history obtained from family members and close contacts, must also be **documented in the medical record by the physician** to ensure validity and follow-up.
- Follow RAI User's Manual for coding
- Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:
 1. the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), and
 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Section GG – Functional Abilities and Goals

Section GG		Functional Abilities and Goals - Admission (Start of SNF PPS Stay)
GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01		
Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).		
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 and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.		
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns		
1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist; including fasteners; does not include footwear.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

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) Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03		
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 and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.		
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns		
3. Discharge Performance		
Enter Codes in Boxes ↓		
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist; including fasteners; does not include footwear.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG – Functional Abilities and Goals

Section GG		Functional Abilities and Goals - Admission (Start of SNF PPS Stay)	
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01			
Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).			
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. <i>Activities may be completed with or without assistive devices.</i>			
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 and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.			
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns			
1. Admission Performance	2. Discharge Goal		
↓ Enter Codes in Boxes ↓			
<input type="text"/>	<input type="text"/>	<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="text"/>	<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	<input type="text"/>	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. PSI
<input type="text"/>	<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="text"/>	<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	<input type="text"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
<input type="text"/>	<input type="text"/>	<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
<input type="text"/>	<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG		Functional Abilities and Goals - Admission (Start of SNF PPS Stay)	
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) - Continued Complete only if A0310B = 01			
Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).			
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. <i>Activities may be completed with or without assistive devices.</i>			
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 and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.			
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns			
1. Admission Performance	2. Discharge Goal		
↓ Enter Codes in Boxes ↓			
<input type="text"/>	<input type="text"/>	<input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
<input type="text"/>	<input type="text"/>	<input type="text"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P; Picking up object
<input type="text"/>	<input type="text"/>	<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P; Picking up object
<input type="text"/>	<input type="text"/>	<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	<input type="text"/>	<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="text"/>	<input type="text"/>	<input type="text"/>	Q1. Does the resident use a wheelchair and/or scooter? 0. No → Skip to GG0130, Self Care (Discharge) 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="text"/>	<input type="text"/>	<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	<input type="text"/>	RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="text"/>	<input type="text"/>	<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="text"/>	<input type="text"/>	<input type="text"/>	SS1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

Section GG – Functional Abilities and Goals

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) Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03		
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 and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.		
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns		
3. Discharge Performance Enter Codes in Boxes ↓		
<input type="checkbox"/>	<input type="checkbox"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="checkbox"/>	<input type="checkbox"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="checkbox"/>	<input type="checkbox"/>	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="checkbox"/>	<input type="checkbox"/>	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="checkbox"/>	<input type="checkbox"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	<input type="checkbox"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="checkbox"/>	<input type="checkbox"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
<input type="checkbox"/>	<input type="checkbox"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
<input type="checkbox"/>	<input type="checkbox"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="checkbox"/>	<input type="checkbox"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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) - Continued Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03		
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 and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.		
If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns		
3. Discharge Performance Enter Codes in Boxes ↓		
<input type="checkbox"/>	<input type="checkbox"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
<input type="checkbox"/>	<input type="checkbox"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="checkbox"/>	<input type="checkbox"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="checkbox"/>	<input type="checkbox"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="checkbox"/>	<input type="checkbox"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="checkbox"/>	<input type="checkbox"/>	Q3. Does the resident use a wheelchair and/or scooter? 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="checkbox"/>	<input type="checkbox"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="checkbox"/>	<input type="checkbox"/>	RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="checkbox"/>	<input type="checkbox"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="checkbox"/>	<input type="checkbox"/>	SS3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

Section GG – Interim Payment Assessment

Section GG		Functional Abilities and Goals - Interim Payment Assessment
GG0130. Self-Care (Assessment period is the last 3 days)		
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.		
<p>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. <i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent – Resident completes the activity by him/herself with no assistance from a helper.</p> <p>05. Setup or clean-up assistance – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>If activity was not attempted, code reason:</p> <p>07. Resident refused</p> <p>09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.</p> <p>10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)</p> <p>88. Not attempted due to medical condition or safety concerns</p>		
5. Interim Performance		
Enter Codes in Boxes ↓		
● <input type="text"/> <input type="text"/> \$	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.	
● <input type="text"/> <input type="text"/> \$	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.	
● <input type="text"/> <input type="text"/> \$	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.	

GG0170. Mobility		(Assessment period is the last 3 days)
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.		
<p>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. <i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent – Resident completes the activity by him/herself with no assistance from a helper.</p> <p>05. Setup or clean-up assistance – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>If activity was not attempted, code reason:</p> <p>07. Resident refused</p> <p>09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.</p> <p>10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)</p> <p>88. Not attempted due to medical condition or safety concerns</p>		
5. Interim Performance		
Enter Codes in Boxes ↓		
● <input type="text"/> <input type="text"/> \$	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.	
● <input type="text"/> <input type="text"/> \$	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.	
● <input type="text"/> <input type="text"/> \$	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.	
● <input type="text"/> <input type="text"/> \$	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).	
● <input type="text"/> <input type="text"/> \$	F. Toilet transfer: The ability to get on and off a toilet or commode.	
● <input type="text"/> <input type="text"/> \$	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100, Appliances	
● <input type="text"/> <input type="text"/> \$	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.	
● <input type="text"/> <input type="text"/> \$	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.	

Section GG Documentation

- Pay attention to time frames for collecting data – different days for admission vs. discharge vs. IPA.
- Follow RAI User's Manual for coding.
- Care plan at least one discharge goal (SNF QRP).
- **QUALIFIED CLINICIAN:** Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.



Interviews: BIMS, PHQ-9©, Pain, Daily & Activity Preferences

- Follow RAI User's Manual for coding – do NOT go off script!
- Ideally, on or just before the ARD (never after the ARD).
- Interviewer to sign at Z0400.
- Complete staff assessment if resident is rarely/never understood.
- Use the same Pain Intensity rating or descriptor scale whenever possible (numeric vs. verbal descriptor).

Section E: Behavior + Documentation

- Documentation must reflect the specific behavior(s) including:
 - Frequency
 - Duration
 - Interventions to prevent, manage, reduce
 - Resident response to interventions
- Care plan must reflect the specific behavior(s), goal(s), interventions and IDT members responsible.
- Medical record must reflect progress towards above goal(s).
- Documentation must be present to reflect interactions with the physician, resident, family/resident representative.

Section M:

Skin Conditions + Documentation

- Photographs are priceless supplements to clinician documentation.
- Follow facility policy re: frequency of wound, pressure ulcer/injury and other skin condition documentation.
- Braden, Norton, other pressure ulcer/injury risk assessments (F686). Many clinicians utilize a standardized pressure ulcer/injury risk assessment tool to assess a resident's PU/PI risks upon admission, weekly for the first four weeks after admission, then monthly or whenever there is a change in the resident's condition. Also, follow your facility's policy.
- Document size and depth as well as condition of surrounding skin, quality and quantity of drainage, presence of odor.
- Record treatment and frequency as well as resident's response.
- Document all contacts with physician and other clinicians as well as the resident and family/resident representative.

Section N

Medications + Documentation

- ALL physician orders must be dated and signed. Every medication ordered should have a corresponding diagnosis or specific symptom (physician).
- MAR documentation should be complete – no holes in the record whether paper or electronic. Same applies to TAR documentation.
- Injection sites should be recorded (don't forget to rotate frequent injections, i.e. insulin, heparin, Lovenox).
- PRN medication documentation must include the reason as well as the result of the medication.
- Documentation of GDR (Gradual Dose Reduction) is essential, including all attempts & results as well as when GDR is contraindicated (physician documentation).
- Drug Regimen Review (DRR) documentation must be complete and the reviewed must be able to follow identification of potential clinically significant medication issues, contact with a physician and follow-up of prescribed/recommended actions. Dating and timing of all such interactions and interventions is critical.
- Monthly Medication Review by your pharmacist is different from DRR.
- Don't forget the AIMS scale when antipsychotics are initiated and periodically as long as in use.
- Documentation of test results, i.e. INR for resident taking warfarin or glucose values for diabetic resident, should be found in the medical record as well as any/all communication with physician or physician extender.

Therapy Services Documentation

Document as often as the clinician's judgment dictates but no less than the frequency required in Medicare policy...required documentation:

- Evaluation and Plan of Care (may be one or two documents)
- Certification (physician/NPP approval of the plan) and recertifications
- Progress Reports (including Discharge Notes)
- Treatment notes for each treatment day

Section O

Restorative Nursing Programs + Documentation

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

- Periodic evaluation (documentation) by the licensed nurse must be present in the resident's medical record. Remember to include the resident's response to the program(s).
- Reassess progress, goals and duration/frequency as part of the care planning process.
- Use flowsheets to verify provision of program(s) in addition to progress notes. Record time accurately.

Section O

Influenza/Pneumococcal Vaccine + Documentation

- Physician orders for vaccine must be signed and dated.
- Informed consent must be documented.
- MAR must reflect vaccination administration and location.
- Resident response to vaccination should be recorded.
- While Section O addresses only Influenza and Pneumococcal vaccines, ensure each resident's medical record contains immunization and vaccination information including TB status, shingles vaccine(s), Tetanus, etc. and that their immunization/vaccination status is up to date.

Baseline Care Plan (F655)

The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must— (i) Be **developed within 48 hours of a resident's admission**. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—

- Initial goals based on admission orders.
- Physician orders.
- Dietary orders.
- Therapy services.
- Social services.
- PASARR recommendation, if applicable.

And...

- Intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission.
- Baseline care plan should strike a balance between conditions and risks affecting the resident's health and safety, and what is important to him or her, within the limitations of the baseline care plan timeframe.
- Baseline care plan must reflect the resident's stated goals and objectives, and include interventions that address his or her current needs. It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

Baseline Care Summary

- The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan **by completion of the comprehensive care plan**. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. This summary must include:
 - Initial goals for the resident
 - A list of current medications and dietary instructions and
 - Services and treatments to be administered by the facility and personnel acting on behalf of the facility
 - Any updated information based on the details of the comprehensive care plan, as necessary

And...

- The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable.
- Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the baseline care plan.

Comprehensive Care Plan (F656 + F657)

- Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.
- Care plans must include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward his/her goal(s).
- The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

When and Who

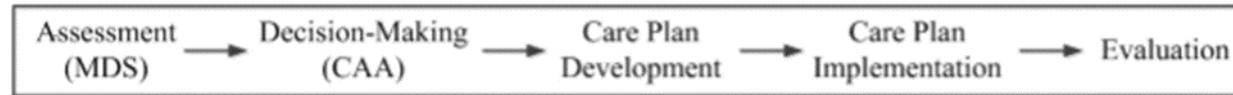
A comprehensive care plan must be— (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to—

- ❖ The attending physician.
- ❖ A registered nurse with responsibility for the resident.
- ❖ A nurse aide with responsibility for the resident.
- ❖ A member of food and nutrition services staff.
- ❖ To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
- ❖ Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

And...

- Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.
- The comprehensive care plan must address a resident's preference for future discharge, as early as upon admission, to ensure that each resident is given every opportunity to attain his/her highest quality of life. This encourages facilities to operate in a person-centered fashion that addresses resident choice and preferences.

RAI Process



- Care plans are developed after data collection (MDS) and decision-making (Care Area Assessments).
- The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

Care Area Assessments

1. Delirium	2. Cognitive Loss/Dementia
3. Visual Function	4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential	6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being	8. Mood State
9. Behavioral Symptoms	10. Activities
11. Falls	12. Nutritional Status
13. Feeding Tubes	14. Dehydration/Fluid Maintenance
15. Dental Care	16. Pressure Ulcer/ <i>Injury</i>
17. Psychotropic Medication Use	18. Physical Restraints
19. Pain	20. Return to Community Referral

Comprehensive Care Plan + Documentation

- Comprehensive Care Plan must reflect MDS data as well as other contributing assessments and CAA documentation.
- Quarterly progress notes to describe progress towards goals identified on the care plan.

Discharge Summary (F661)

- Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
 - A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
 - A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
 - Reconciliation of all pre-discharge medications with the resident's post discharge medications (both prescribed and over-the-counter).
 - A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services
- INTENT of §483.21(c)(2): To ensure the facility communicates necessary information to the resident, continuing care provider and other authorized persons at the time of an anticipated discharge.

Why Discharge Summary?

- The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plans for care after discharge. A discharge summary must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. The discharge summary may help reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care.
- In the case of discharge to a non-institutional setting such as the resident's home, provision of a discharge summary, with the resident's consent, to the resident's community-based physicians/practitioners allows the resident to receive continuous and coordinated, person-centered care.
- For residents who are being discharged from the facility to another health care facility, the discharge summary enables the receiving facility to provide appropriate and timely care. The medical record must identify the receiving facilities for which or physicians/practitioners to whom the discharge summary is provided.

Timing of Discharge Summary

- The discharge summary contains necessary medical information that the facility must furnish at the time the resident leaves the facility, to the receiving provider assuming responsibility for the resident's care after discharge.
- The discharge summary may be furnished in either hard copy or electronic format, if the provider assuming responsibility for the resident's care has the capacity to receive and use the discharge summary in electronic format. Delays in preparing and forwarding the discharge summary hinder the coordination required to provide optimal care to the resident.
- The medical record must contain the discharge summary information and identify the recipient of the summary.

Beneficiary Notices (F582)

SNFABN

- Facilities must issue the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) to residents/beneficiaries prior to providing care that Medicare usually covers, but may not pay for, because the care is:
 - Not medically reasonable and necessary or
 - Is considered custodial

The SNFABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. If the SNF provides the beneficiary with SNFABN, form CMS-10055, the facility has met its obligation to inform the beneficiary of his or her potential liability for payment and related standard claim appeal rights. Issuing the Notice to Medicare Provider Non-coverage (NOMNC), form CMS-10123, to a beneficiary only conveys notice to the beneficiary of his or her right to an expedited review of a service termination and does not fulfill the facility's obligation to advise the beneficiary of potential liability for payment. A facility must still issue the SNFABN to address liability for payment.

Beneficiary Notices

NOMNC

- The NOMNC (CMS-10123) informs the beneficiary of his or her right to an expedited review of a services termination. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. The SNF may not issue this notice if the beneficiary exhausts the Medicare covered days as the number of SNF benefit days is set in law and the Quality Improvement Organization (QIO) cannot extend the benefit period. Thus, a service termination due to the exhaustion of benefits is not considered a termination for “coverage” reasons. The NOMNC is issued when all covered services end for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. In most cases when all covered services end for coverage reasons, a SNF provider will issue:
 - NOMNC or
 - NOMNC and the SNFABN
- In cases where all Medicare covered services are ending, the beneficiary is being discharged and is not requesting an expedited review, only the NOMNC is required.

Beneficiary Notices + Documentation

- Beneficiary must be notified far enough in advance so that an informed decision regarding potential liability can be made without undue pressure.
- Part B ABN: CMS-R-131 issued for initiation (non-coverage of services), reduction and termination of services. The beneficiary has the right to a standard or expedited claims appeal.
- NOMNC (CMS-10123) is also issued for Part B services.
- DENC (CMS-10124) is used when the beneficiary has requested an expedited review.
- For more information, go to: www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Triple Check

- Do you have a Triple Check process in place?
- Triple Check
 - Internal audit of claims before submission – validation and error detection
 - Technical errors (inaccurate modifiers, incorrect ARD)
 - Process errors (data entry, i.e. MBI, Resident name, etc.)
 - Documentation errors (inconsistencies in the record vs. the MDS Item Set)
 - Decrease chances of being audited
- Do you know that you must transmit MDS assessments and they must be accepted by QIES ASAP before you bill for services?

Triple Check Participants

- Administrator
- Business Office Manager/Biller
- Director of Nursing
- MDS Coordinator
- Medical Records
- Facility Rehab/Therapy Director
- Central Supply Manager
- Others as designated by Administrator

Facility Assessment (F838)

- The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:
 - (1) The facility's resident population, including, but not limited to,
 - (i) Both the number of residents and the facility's resident capacity;
 - (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
 - (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
 - (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population and
 - (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

And...

- (2) The facility's resources, including but not limited to,
 - (i) All buildings and/or other physical structures and vehicles;
 - (ii) Equipment (medical and non- medical);
 - (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
 - (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
 - (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
 - (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.
- (3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

Last Words...

- **Audit** your documentation process now and periodically to ensure it meets facility policy/standards as well as State and Federal regulations. Look at all elements we've discussed today – add any items that are pertinent to your facility.
- Don't forget that your compliance with Quality Measures and QRPs come directly from your MDS records. Audit as well when looking at QMs and QRPs.
- Utilize your QA&A and QAPI processes to determine root causes and resolutions as well as continued monitoring to ensure highest quality documentation.
- Ensure resident Advance Directives are found in the medical record.

And...

- Remember there are documentation requirements for Involuntary Discharge of residents from your facility.
- Utilize Appendix PP for assistance with policies/procedures and documentation requirements.
- Utilize the Critical Element Pathways to audit how your facility is doing with documentation of what surveyors are looking for.
- What's your facility's policy on Copy & Paste with your electronic records?
- Never log into an EMR with anyone else's credentials!

Resources

- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>
Chapter 8 – Medicare Benefit Policy Manual...Coverage of Extended Care (SNF) Services
- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf>
Chapter 4 - Medicare General Information, Eligibility, and Entitlement...Physician Certification and Recertification of Services
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
MDS 3.0 RAI Manual
- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html>
State Operations Manual...Appendix PP = Interpretive Guidelines for LTC Requirements of Participation (RoPs)
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
Nursing Homes...Long-Term Care Survey
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-Resources.zip>
Survey Resources...LTC Survey Pathways
- <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni/>
Beneficiary Notices Initiative (BNI)
- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
Chapter 15 – Medicare Benefit Policy Manual...220.3 – Documentation Requirements for Therapy Services
- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>
PDPM Website

Additional Resources

- <https://www.briggshealthcare.com/Survey-Guide> and <https://www.briggshealthcare.com/Survey-Guide-Interpretive-Guidelines-for-Long-Term-Care-eManual>
Survey Guide – Interpretive Guidelines for Long-Term Care
- <https://www.briggshealthcare.com/MDS-3.0-Users-Manual-v1.17-October-2019-Edition> and <https://www.briggshealthcare.com/MDS-3.0-Users-Manual-V1.17.1-October-2019-Edition-eManual>
MDS 3.0 User’s Manual V1.17.1 – October 2019
- <https://www.briggshealthcare.com/Baseline-Care-Plan>
Baseline Care Plan
- <https://www.briggshealthcare.com/Baseline-Care-Summary>
Baseline Care Plan Summary
- <https://www.briggshealthcare.com/Triple-Check>
Triple Check
- <https://www.briggshealthcare.com/Drug-Regimen-Review-MDS-SNF-QRP>
Drug Regimen Review
- <https://www.briggshealthcare.com/Facility-Assessment> and <https://www.briggshealthcare.com/RoP-Facility-Assessment-Toolkit>
Facility Assessment
- <http://bok.ahima.org/Pages/Long%20Term%20Care%20Guidelines%20TOC>
AHIMA’s Long-Term Care Health Information Practice and Documentation Guidelines

About our speaker



Mary Madison, RN, RAC-CT, CDP, is a registered nurse with over 45 years of healthcare experience, including 40 years in long-term care. She has held positions of Director of Nursing in a 330-bed SNF, DON in two 60-bed SNFs, Reviewer with Telligen (Iowa QIO), Director of Continuing Education, Manager of Clinical Software Support, Clinical Software Implementer and Clinical Educator. Mary has conducted numerous MDS training and other educational sessions across the country in the past two+ decades. Mary joined Briggs Healthcare as their LTC/Senior Care Clinical Consultant in July 2014.

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Q&A

Thank you for attending!

Recording and slides available at
simpleitc.com/documentation
& briggshealthcare.blog