RUGs III
Case Mix Supportive Documentation Guidelines
MDS 3.0 Assessments

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
Section B: Hearing, Speech, and Vision (7-day look back)		
B0100 Comatose (CPS)	**Clinically Complex** **Impaired Cognition**	**Does require:** • Diagnosis of coma or persistent vegetative state that is active within the observation period **Does NOT include:** • Resident in advanced stages of progressive neurologic disorders (i.e. Alzheimer's)
B0700 Makes Self Understood (CPS)	**Impaired Cognition**	**Does require:** • Example(s) of the resident's ability and degree of impairment to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination **Does include:** • Reduced voice volume • Difficulty in producing sounds • Difficulty in finding the right word, making sentences, writing, and/or gesturing
Section C: Cognitive Patterns (7-day look back)		
C0200 Repetition of Three Words (BIMS)	**Impaired Cognition**	**Does require:** • Validation of completion of item C0200 at Z0400 on or before the ARD date **OR** • Evidence of resident interview of BIMS items in medical record **within the observation period**
C0300 A,B,C Temporal Orientation (BIMS)	**Impaired Cognition**	**Does require:** • Validation of completion of item C0300 A,B,C at Z0400 on or before the ARD date **OR** • Evidence of resident interview of BIMS items in medical record **within the observation period**
C0400 A,B,C Recall (BIMS)	**Impaired Cognition**	**Does require:** • Validation of completion of item C0400 A,B,C at Z0400 on or before the ARD date **OR** • Evidence of resident interview of BIMS items in medical record **within the observation period**
C0700 Short-Term Memory (CPS)	**Impaired Cognition**	**Does require:** • Example(s) describing an event 5 minutes after it occurred if you can validate the resident's response **OR** • Example(s) describing the lack of follow through on a direction given 5 minutes earlier • **Example(s) must reference 5 minute time frame**

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
C1000 Cognitive Skills for Daily Decision Making (CPS)	**Impaired Cognition**	**Does require:** • Example(s) demonstrating degree of compromised decision-making **about tasks of everyday living** **Does include:** • Choosing clothing • Knowing when to go to meals • Using environmental cues to organize and plan • Seeking information from others to plan the day **Does NOT include:** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff
Section D: Mood (14-day look back)		
D0200A-I, Column 2 Resident Mood Interview Symptom Frequency	**Clinically Complex**	**Does require:** • Validation of completion of items D0200 A-I at Z0400 on or before the ARD **OR** • Evidence of resident mood interview (PHQ-9) in medical record **within the observation period**
D0500A-J, Column 2 Staff Assessment of Resident Mood Symptom Frequency	**Clinically Complex**	**Does require:** • Example(s) that demonstrates the resident's mood (specific to each D0500A-J item) • Evidence of daily documentation supporting frequency of mood
Section E: Behavior (7-day look back)		
E0100A Hallucinations	**Behavior Problems**	**Does require:** • Example(s) of a resident's perception of the presence of something that is not actually there **Does include:** • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli
E0100B Delusions	**Behavior Problems**	**Does require:** • Example(s) of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary **Does NOT include:** • A resident's expression of a false belief when the resident easily accepts a reasonable alternative explanation • A belief that cannot be shown to be false or is impossible to determine if it is false
E0200A (code 2 or 3) Physical Behavioral Symptoms directed toward others	**Behavior Problems**	**Does require:** • Example(s) of physical behavioral symptoms directed toward others • Daily documentation supporting frequency **Does include:** • Hitting, kicking, pushing, scratching, grabbing, abusing others sexually
E0200B (code 2 or 3) Verbal Behavioral Symptoms directed toward others	**Behavior Problems**	**Does require:** • Example(s) of verbal behavioral symptoms directed toward others • Daily documentation supporting frequency **Does include:** • Threatening others, screaming at others, cursing at others

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
E0200C (code 2 or 3) Other Behavioral Symptoms not directed toward others	**Behavior Problems**	**Does require:** • Example(s) of other behavioral symptoms NOT directed toward others • Daily documentation supporting frequency **Does include:** • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds
E0800 (code 2 or 3) Rejection of Care	**Behavior Problems**	**Does require:** • Example(s) of the resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being • Daily documentation supporting frequency **Does NOT include:** • Behaviors that have already been addressed and determined to be consistent with resident's values, preferences or goals
E0900 (code 2 or 3) Wandering	**Behavior Problems**	**Does require:** • Example(s) of moving from place to place with or without a specified course or known direction • Daily documentation supporting frequency **Does NOT include:** • Pacing • Traveling via a planned course to another specific place (dining room or activity)
Section G: Functional Status (7-day look back)		
G0110A, Column 1&2 Bed Mobility **G0110B**, Column 1&2 Transfer **G0110I**, Column 1&2 Toilet Use **G0110H**, Column 1 ONLY Eating	**Extensive Services** **Rehabilitation** **Special Care** **Clinically Complex** **Impaired Cognition** **Behavior Problems** **Reduced Physical Function**	**Does require:** • Documentation 24 hours per day/observation period while a resident • Initials and dates to authenticate the services provided including signatures and titles to authenticate initials • Staff who actually provided the service and/or person taking responsibility for the service must initial documentation • The ADL key for self-performance and support provided must include all the MDS key options and be equivalent to the intent and definition of the MDS key (key of "7" self performance is optional) • The ADL key must be posted and/or readily available to all staff reporting • ADL values • If using narrative notes to support ADLs, each episode must include the specific ADL(s) and degree of self-performance and support provided. Wording must be equivalent to MDS key definitions for example • "extensive (weight-bearing) assist of one for transfers" • ADL documentation must be maintained as part of the legal medical record and accessible during the on-site review • Facility to designate **one** ADL tool to be used for the **entire** review when more than one tool is used. **Does NOT include:** • Individuals hired, compensated or not, outside the facility's management and administration • Services provided other than by staff in the facility; such as family, hospice staff, nursing/CNA students and other visitors

Assessments with an ARD on or after 10/1/2013

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
Section H: Bladder and Bowel (7-day look back)		
H0200C Current Urinary Toileting Program or Trial Restorative Nursing	**Rehabilitation** **Impaired Cognition** **Behavior Problems** **Reduced Physical Function**	**Does require:** • Documentation of a toileting program trial • Documentation of a response to the trial toileting program • Implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern • Evidence that the program was communicated verbally and through a care plan, flow records, and a written report • Documentation of resident's **progress towards the program goal(s)** by a licensed nurse within the observation period • **Systematic** toileting program that is being managed during 4 or more days of the 7-day look back period **Does include:** • Program if only used by day (when documented that the resident does not want awakened at night) **Does NOT include:** • Less than 4 days of a systematic toileting program • Simply tracking continence status • Changing pads or wet garments • Random assistance with toileting or hygiene
H0500 Bowel Toileting Program Restorative Nursing	**Rehabilitation** **Impaired Cognition** **Behavior Problems** **Reduced Physical Function**	**Does require:** • Implementation of an individualized, resident-specific bowel toileting program that was based on an assessment of the resident's unique bowelpattern • Evidence that the program was communicated verbally and through a care plan, flow records, and a written report • Documentation of resident's **progress towards the program goal(s)** by a licensed nurse within the observation period **Does NOT include:** • Simply tracking of bowel continence status • Changing pads or soiled garments • Random assistance with toileting or hygiene
Section I: Active Diagnoses (7-day and 60-day look back)		
Active Diagnosis Definition: A physician documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death within the 7-day look back period **Does require:** • Physician documented diagnosis in the 60-day look back period • Documentation supporting active diagnosis in the 7-day look back period • Documentation related to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis • Current care plan **updated within 7-day observation period if used as supporting documentation for case mix review** **Does include:** • **Functional limitations** – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis • **Nursing monitoring** – nursing monitoring includes clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.) **Does NOT include:** • Conditions that have been resolved, do not affect the resident's current status or do not drive the resident's plan of care during the 7-day look back period; **these would be considered inactive diagnoses**		

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
I2000 Pneumonia	Special Care Clinically Complex	See active diagnosis definition Does NOT include: • A hospital discharge note referencing pneumonia during hospitalization
I2100 Septicemia I2900 Diabetes Mellitus (DM) I4900 Hemiplegia/ Hemiparesis	Clinically Complex	See active diagnosis definition Septicemia does NOT include: • A hospital discharge note referencing septicemia during hospitalization
I4300 Aphasia I4400 Cerebral Palsy I5100 Quadriplegia I5200 Multiple Sclerosis (MS)	Special Care	See active diagnosis definition Quadriplegia does require: • Physician documentation of an injury to the spinal cord that causes total paralysis of all four limbs (arms and legs) Quadriplegia does NOT include: • Functional quadriplegia • Complete immobility due to severe physical disability or frailty that extends to all limbs
Section J: Health Conditions (7-day look back)		
J1550A Fever	Special Care	Does require: • Consistent route (rectal, oral, etc.) of temperature measurement between the baseline and the elevated temperature • Fever of 2.4 degrees F. above the baseline • A baseline temperature established prior to the ARD Does include: • A temperature of 100.4 degrees F. on admission is a fever
J1550B Vomiting	Special Care	Does require: • Documentation of regurgitation of stomach contents
J1550C Dehydrated	Special Care Clinically Complex	Does require 2 or more of the 3 potential dehydration indicators listed below: • Usually takes in less than 1500 cc of fluid daily • One or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values, etc. • Fluid loss that exceeds amount of fluids taken in Does NOT include: • A hospital discharge note referencing dehydration during hospitalization unless 2 of the 3 dehydration indicators are present and documented • A diagnosis of dehydration

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
J1550D Internal Bleeding	Clinically Complex	Does require: • Documentation of frank or occult blood Does include: • Black, tarry stools • Vomiting "coffee grounds" • Hematuria • Hemoptysis • Severe epistaxis (nosebleed) that requires packing Does NOT include: • Nosebleeds that are easily controlled • Menses • Urinalysis that shows a small amount of red blood cells
Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 60-day look back)		
K0300 (code 1 or 2) Weight Loss	Special Care	Does require: • Evidence of the resident's weight loss of 5% or more in last month OR • 10% or more in last 6 months • Percentage based on the actual weight • Documentation supporting the expressed goal for the weight loss for code of "1" Does include: • Mathematical rounding • Planned or unplanned Does NOT include: • A physician ordered weight loss regimen when the diet is not intended to induce weight loss
K0510A Column 1 or 2 Parenteral / IV Feeding	Extensive Services ADL Score	Does require: • Nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, administered for nutrition or hydration Does include: • Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous) • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently • IV at KVO (keep vein open) • IV fluids contained in IV piggyback • Hypodermoclysis and sub-Q ports in hydration therapy • IV fluids administered for the purpose of "prevention" of dehydration if specifically documented for nutrition or hydration Does NOT include: • IV medications • IV fluids used to reconstitute and/or dilute meds • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay • IV fluids administered solely as flushes • IV fluids administered in conjunction with chemotherapy or dialysis

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
K0510B Column 1 or 2 Feeding Tube	Special Care Clinically Complex ADL Score	Does require: • Nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, administered for **nutrition** or **hydration** Does include: • NG tubes, gastrostomy tubes, J-tubes, PEG tubes • Any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the GI system
K0710A3 Proportion of Total Calories the Resident Received Through Parenteral or Tube Feeding **During Entire 7 days**	Special Care Clinically Complex ADL Score	Does require: • Documentation to support the proportion of calories actually received for nutrition or hydration through parenteral or tube feeding **during the entire 7-day observation period** **For residents receiving both P.O. nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:** 1. Calories tube feeding provided within observation period 2. Calories oral feeding provided within observation period 3. Percent of total calories provided by tube feeding
K0710B3 Average Fluid Intake Per Day by IV or Tube Feeding **During Entire 7 days**	Special Care Clinically Complex ADL Score	Does require: • Documentation to support average fluid intake per day by IV and/or tube feeding **during the entire 7-day observation period** **Documentation must demonstrate how the facility calculated the average fluid intake the tube feeding provided and must include:** 1. Adding the total amount of fluid received each day by IV or tube feedings **only** 2. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day (Divide by 7 even if the resident did not receive IV fluids or tube feeding on each of the 7 days)
Section M: Skin Conditions (7-day look back)		
M0300A Stage 1 **M0300B1** Stage 2 **M0300C1** Stage 3 **M0300D1** Stage 4 **M0300F1** Unstageable Due to Slough/Eschar	Special Care	• **Description of pressure ulcer(s) within the 7-day observation period such as location, dimensions, drainage, tissue color, etc.** • **Documentation of highest reported stage of pressure ulcer(s) such as location, dimensions, drainage, tissue color and stage, etc.** • **Documentation must include complete history of pressure ulcer(s) when the reported stage is numerically higher than the current description** Does NOT require: • **Staging of current pressure ulcer(s) if highest reported stage and history of ulcer(s) are documented** Does NOT include: • Pressure ulcers that are healed before the look-back period (are reported at M0900) • A pressure ulcer surgically repaired with a flap or graft If pressure is NOT the primary cause • **Oral mucosal ulcers caused by pressure (reported at L0200C)**
M1030 Venous/Arterial Ulcers	Special Care	Does require: • Description of the ulcer **such as** location, dimensions, drainage, tissue color, etc.

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1040A Infection of the Foot	**Clinically Complex**	**Does require:** • Documentation of signs and symptoms of infection of the foot **Does include:** • Cellulitis • Purulent drainage **Does NOT include:** • Ankle problems • Pressure ulcers coded in M0300-M0900
M1040B Diabetic Foot Ulcer	**Clinically Complex**	**Does require:** • Description of diabetic foot ulcer **such as** location and appearance **Does NOT include:** • Pressure ulcers coded in M0300 through M0900 • Pressure ulcers that occur on residents with diabetes mellitus
M1040C Other Open Lesion on the Foot, (e.g. cuts, fissures)	**Clinically Complex**	**Does require:** • Description of open lesion **such as** location and appearance **Does NOT include:** • Pressure ulcers coded in M0300-M0900
M1040D Open Lesion Other Than Ulcers, Rashes, Cuts	**Special Care**	**Does require:** • Description of the open lesion **such as** location and appearance **Does include:** • Skin lesions that develop as a result of diseases and conditions such as syphilis and cancer **Does NOT include:** • Pressure ulcers coded in M0300-M0900 • Skin tears, cuts, abrasions, rashes
M1040E Surgical Wound	**Special Care**	**Does require:** • Description of the surgical wound **such as** location and appearance **Does include:** • Any healing or non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body • Pressure ulcers that are surgically repaired with grafts and flap procedures **Does NOT include:** • Healed surgical sites and healed stomas • Lacerations that require suturing or butterfly closure • PICC sites, central line sites, peripheral IV sites • Pressure ulcers that have been surgically debrided
M1040F Burn	**Clinically Complex**	**Does require:** • Description of the second or third degree burn **such as** location and appearance **Does include:** • May be in any stage of healing • Skin and tissue injury caused by heat or chemicals **Does NOT include:** • First-degree burns (changes in skin color only)

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200A Pressure Reducing Device/chair **M1200B** Pressure Reducing Device/bed	Special Care	**Does require:** • Documentation of equipment aimed at reducing pressure away from areas of high risk **Does include:** • Foam, air, water, gel, or other cushioning • Pressure relieving, reducing, redistributing devices **Does NOT include:** • Egg crate cushions of any type • Doughnut or ring devices
M1200C Turning/ Repositioning Program	Special Care	**Does require:** • A consistent **program** for changing the resident's position and realigning the body • Documentation of interventions and frequency of program • Monitoring and reassessing the program to determine the effectiveness of the interventions • Documentation by licensed nurse describing an evaluation of the resident's response to the program within the observation
M1200D Nutrition or Hydration Intervention to Manage Skin Problems	Special Care	**Does require:** • Confirmation or suspicion of nutritional deficiencies through a nutritional assessment • Description of specific skin condition • Nutrition or hydration factors that are influencing the skin problem and or wound healing • Interventions are specifically tailored to resident's needs, condition and prognosis **Does include:** • Vitamins and/or supplements
M1200E Pressure Ulcer Care	Special Care	**Does require:** • Intervention for treating pressure ulcers coded at M0300 **Does include:** • Use of topical dressings • Chemical or surgical debridement • Wound irrigations • Negative pressure wound therapy (NPWT) • Hydrotherapy
M1200F Surgical Wound Care	Special Care	**Does require:** • Intervention for treating or protecting any type of surgical wound **Does include:** • Topical cleansing • Wound irrigation • Application of antimicrobial ointments • Application of dressings of any type • Suture/staple removal • Warm soaks or heat application **Does NOT include:** • Post-operative care following eye or oral surgery • Surgical debridement of pressure ulcer • Observation of the surgical wound

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200G Application of Non-surgical Dressings; Other Than to Feet	Special Care	**Does require:** • Application of non-surgical dressing (with or without topical medications) to the body other than to the feet **Does include:** • Compression bandages • Dry gauze dressings • Dressings moistened with saline or other solutions • Transparent dressings • Hydrogel dressings • Dressings with hydrocolloid or hydroactive particles • Dressing application to the ankle **Does NOT include:** • Non-surgical dressings for pressure ulcers other than to foot; use ulcer care (M1200E) • Band-Aids
M1200H Application of Ointments/Medications Other Than to Feet	Special Care	**Does require:** • Application of ointments/medications (used to treat a skin condition) other than to feet **Does include:** • Topical creams • Powders • Liquid sealants • Cortisone • Antifungal preparation • Chemotherapeutic agents **Does NOT include:** • Ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers • Ointments used to treat non-skin conditions (e.g., nitropaste for chest pain)
M1200I Applications of Dressings to Feet	Clinically Complex	**Does require:** • Dressing changes to the feet (with or without topical medication) • Interventions to treat any foot wound or ulcer other than a pressure ulcer **Does NOT include:** • Dressing application to the ankle
Section N: Medications (7-day look back)		
N0300 Injections	Clinically Complex	**Does require:** • The number of days that the resident received any medication, antigen, vaccine, etc., by subcutaneous, intramuscular or intradermal injection while a resident of the facility **Does include:** • For subcutaneous pumps, count only the number of days that the resident actually required a subcutaneous injection to restart the pump • Insulin injections

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
Section O: Special Treatments, Procedures, and Programs (14-day look back)		
O0100 Special Treatments	Informational Only	• Includes special treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff • Does NOT include services provided solely in conjunction with a surgical procedure (pre- and post-operative) or diagnostic procedure • Items O0100 include while NOT a resident and while a resident
O0100A Chemotherapy	Clinically Complex	Does require: • Administration of any type of chemotherapy agent (anticancer drug) given by any route for the sole purpose of cancer treatment Does include: • A nurse's note that resident went out for chemotherapy treatment including a corresponding physician order
O0100B Radiation	Special Care	Does require: • Administration of radiation inside or outside of facility Does include: • Intermittent radiation therapy • Radiation administered via radiation implant • A nurse's note that resident went out for radiation treatment including a corresponding physician order
O0100C Oxygen Therapy	Clinically Complex	Does require: • Administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia Does include: • Resident places or removes his/her own oxygen mask, cannula • Oxygen when used in BiPAP/CPAP Does NOT include: • Hyperbaric oxygen for wound therapy
O0100D Suctioning	Extensive Services	Does require: • Administration of nasopharyngeal and/or tracheal suctioning Does include: • Resident performs his/her own tracheal and/or nasopharyngeal suctioning Does NOT include: • Oral suctioning
O0100E Tracheostomy Care	Extensive Services	Does require: • Administration of tracheostomy and/or cannula cleansing Does include: • Changing a disposable cannula • Resident performs his/her own tracheostomy care
O0100F Ventilator or Respirator	Extensive Services	Does require: • Administration of any type of electrically or pneumatically powered closed system mechanical ventilator support device Does include: • Any resident who was in the process of being weaned off the ventilator or respirator Does NOT include: • Times when used as a substitute for BiPAP or CPAP

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100H IV Medications	Extensive Services	Does require: • Administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port Does include: • Epidural, intrathecal, and baclofen pumps • Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids Does NOT include: • Flushes to keep an IV port patent • IV fluids without medication • Subcutaneous pumps • IV medications administered during dialysis or chemotherapy • Dextrose 50% and/or Lactated Ringers
O0100I Transfusions	Clinically Complex	Does require: • Administration of blood or any blood products directly into the bloodstream Does NOT include: • Transfusions administered during dialysis or chemotherapy
O0100J Dialysis	Clinically Complex	Does require: • Administration of peritoneal or renal dialysis that occurred at the facility or another facility Does include: • Hemofiltration • Slow Continuous Ultrafiltration (SCUF) • Continuous Arteriovenous Hemofiltration (CAVH) • Continuous Ambulatory Peritoneal Dialysis (CAPD) • A nurse's note that resident went out for dialysis treatment including a corresponding physician order • Resident performing his/her own dialysis Does NOT include: • IV, IV medication and blood transfusion administered during dialysis
O0400 – Therapies (7-day look back) (A) Speech-Language Pathology Services (SLP) (B) Occupational therapy (OT) (C) Physical therapy (PT)		
General Therapy Requirements Does require: • Only skilled therapy provided while a resident in the facility • Services be directly and specifically related to an active written treatment plan approved by the physician • Services be preceded by an evaluation prior to the start of Restorative services time • Services be of a level of complexity and sophistication, or • Services be provided with an expectation that condition will improve materially in a predictable time • Services be reasonable and necessary for condition		Does NOT include: • Services at the request of the family that are not medically necessary • Non-skilled services (facility election, maintenance treatments, supervision of CNAs) time therapy • Therapy provided prior to admission condition requiring the judgment, knowledge, skills of a Therapist

<table>
<tr><th>MDS 3.0 Item
Location and
Item Description</th><th>RUG-III Categories
Impacted</th><th>Minimum Documentation and Review Standards
Required Within the Specified Observation Period</th></tr>
<tr><td colspan="3">Minutes of Therapy Requirements</td></tr>
<tr><td colspan="3">Does require:
Only skilled therapy minutes be
reported on the MDS
Only skilled services after the initial
evaluation be reported on the MDS
Reimbursable (actual) therapy
otherwise prepare for individualized
Documentation of RTM for each
Family education when the resident
Documentation be differentiated
SLP assistant time between RTM minutes and billable minutes/units
Does include:
Therapist time spent on subsequent reevaluations conducted as part of the treatment process
Time required to adjust equipment or otherwise prepare for individualized therapy
Family education when the resident is present and documented
Does NOT include:
Therapist time spent on documentation or initial evaluation
Conversion of units to minutes or minutes to units
Rounding to the nearest 5th minute
Non-therapeutic rest periods
Treatment or portion of treatment that is not skilled
SLP assistant time
Initial evaluation minutes
Unattended e-stim minutes</td></tr>
<tr><td>Therapy Minutes
O0400A1,2,3
Speech-Language Pathology and Audiology Services

O0400B1,2,3
Occupational Therapy

O0400C1,2,3
Physical Therapy</td><td>Rehabilitation</td><td>Does require:
RTM minutes with associated initials/signature(s) on a daily basis to support the total number of RTM minutes of actual therapy provided
Physician order, treatment plan and assessment</td></tr>
<tr><td>Therapy Days
O0400A4
Speech-Language Pathology and Audiology Services

O0400B4
Occupational Therapy

O0400C4
Physical Therapy</td><td>Rehabilitation</td><td>Does require:
Associated initials/signature(s) on a daily basis to support the total number of days therapy provided
Treatment for 15 minutes or more per day</td></tr>
<tr><td>O0400D2
Respiratory Therapy Days</td><td>Special Care</td><td>Does require:
Physician order that includes a statement of frequency, duration and scope of treatment
Documentation of actual minutes on a daily/shift/occurrence basis
Evidence of licensed nurse training
A respiratory nurse must be proficient in the modalities provided either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws
Does NOT include:
Treatment for less than 15 minutes per day</td></tr>
</table>

MDS 3.0 Item Location and Item Description	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0500A-J Restorative Nursing Program Days	Rehabilitation Impaired Cognition Behavior Problems Reduced Physical Function	Does require: • Documentation of actual minutes on a daily/shift/occurrence basis for each program provided within a 24-hour period • Initials/signature(s) on a daily/shift/occurrence basis to support the total minutes of restorative nursing programs provided • Documentation must include the five criteria to meet the definition of a restorative nursing program: 1. Care plan with measurable objectives and interventions 2. Evaluation of the program by a licensed nurse, i.e., for the case mix review, reassess progress, goals and duration/frequency of each program within the observation period 3. Staff trained in the proper techniques 4. Supervised by nursing 5. No more than 4 residents per supervising staff personnel • Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device within the observation period Does NOT include: • Requirement for physician order • Procedures or techniques carried out by or under the direction of qualified therapists • Movement by a resident that is incidental to care • Treatment for less than 15 minutes per day
O0600 Physician Examinations	Clinically Complex	Does require: • Evidence of an examination by the physician Does include: • Partial or full examination in the facility, in the physician's office or off-site, e.g., while undergoing dialysis • Telehealth visits Does NOT include: • Examinations conducted prior to admission or reentry • Examinations conducted during an ER visit or hospital observation stay • Examination by a Medicine Man or Psychologist (PhD)
O0700 Physician Orders	Clinically Complex	Does include: • Written, telephone, fax, or consultation orders for new or altered treatment • Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or • altered treatment orders and should be counted as a day with order changes Does NOT include: • Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes • Orders written prior to admission or reentry • Activation of a PRN order already on file • Administration of different dosages from an established sliding scale • Monthly Medicare certification/recertification • Orders to increase the RUG classification