Office of MaineCare Services
Case Mix Team

DOCUMENTATION GUIDELINES for Nursing Facilities in Maine

PDPM Nursing Group payment Methodology for Long-Term Care

Effective for Assessments with an ARD on or After 10/1/25

Updated 10/8/25

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Introduction

Accuracy of the MDS 3.0 item responses is very important for many reasons: responses guide the care provided to the resident; Quality Measures assist state survey in identifying potential care problems in a nursing facility; the Medicare Prospective Payment System rates are set based on MDS responses, and long-term care facilities in Maine are reimbursed based on MDS responses.

These Documentation Requirements apply to all Medicare- and Medicaid-certified nursing facilities in Maine that are completing MDS 3.0 assessments for payment purposes on or after October 1, 2025.

SOURCE OF DOCUMENTATION GUIDELINES

According to the RAI manual in Chapter 1, "While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident." Maine has established additional MDS requirements for MaineCare payment and/or quality monitoring purposes.

The information in these Requirements has been compiled in conjunction with the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual), instructions that are printed on the MDS 3.0 form itself, and the Data Submission Specifications for MDS 3.0. Nursing facility personnel should review these resources thoroughly to accurately understand MDS coding and meet all requirements. In some cases, there are specific documentation requirements specifically related to the State of Maine and are utilized as part of the Case Mix Quality Assurance review process to determine appropriateness of MDS coding and accuracy of payments.

In addition to the RAI Manual and Data Submission Specifications, the State of Maine utilizes the MaineCare Benefits Manual Section 67, Chapter I, Nursing Facility Services, and Chapter II, Principles of Reimbursement for Nursing Facilities as a source document for the Documentation Guidelines.

MDS ITEMS FOR REVIEW

While thorough documentation and accurate coding of the MDS is essential for all MDS item responses, the Nursing Component of the PDPM classification system uses a subset of the MDS assessment items; those items have an impact on your facility's long-term care reimbursement rate. As such, these requirements identify only those MDS items used in the Nursing Component of the PDPM system for payment purposes.

OVERALL DOCUMENTATION INSTRUCTIONS

The Assessment Reference Date (ARD) designates the end of the look-back period so that all assessment items refer to the resident's status during the same period of time. The look-back period includes observations and events through the end of the day (11:59 PM) of the ARD. Anything that happens after the ARD will not be captured on the MDS assessment.

All conditions or treatments must have been present or occurred within the designated observation or look-back period, which includes the full 24 hours, ending at 11:59 PM of the Assessment Reference Date (ARD) located at MDS Section A2300. The ARD is defined in Section A of the RAI Manual as the specific end point for look-back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the ARD. Unless otherwise noted on the MDS form, this look-back period, also called the observation period or assessment period, is a 7-day look-back period ending on the ARD. Some assessments may have an observation period of more or less than 7 days, however; the ARD is always the end point for the observation period. With the exception of certain items, the look-back period does not extend into the preadmission period unless the item instructs states otherwise. PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to iQIES and therefore should not be considered when determining the "prior assessment."

Documentation in the clinical record must support all coding on the MDS and reflect care related to the symptom/problem. Documentation must be present for the appropriate look-back period and accurately reflect the resident's status on all shifts. Conflicting documentation identified within the observation period shall be deemed as unsupported documentation

Signature Requirements

Supportive documentation entries must be dated and their authors identified by signature or initials. Signatures are required to authenticate all clinical records. At a minimum, the signature must include the first initial, last name, and title/credential. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there must also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS).

When electronic signatures are used, there must be a written policy in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs and must include safeguards to prevent unauthorized use of electronic signatures.

Corrections

In cases of corrections, obliterations, errors or mistaken entries, the author of the original entry must, at a minimum, draw a line through the incorrect information and include the original author's initials, the date the modification was made and the correct information.

The expectation of the Office of MaineCare Services is that nursing facilities maintain and have readily available supporting original legal medical documentation to include timely access to electronic medical records. All MDS PDPM items require supporting documentation as outlined in this Maine Documentation Guidelines User Guide.

Z0400 Requirements

Z0400 requires the **Signature, Title, Sections and Date Sections Completed** by all people completing any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.

Z0400 certification reads as follows:
"I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment for such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a subset of items within a section should identify which item(s) he/she completed within that section.

MDS assessment date requirements may be found in the RAI Manual, Chapter 2.

Documentation Guidelines for Nursing Facilities in Maine

GUIDELINES TABLE EXPLANATION

The Documentation Guidelines to support coding on the MDS table contains a header per section as well as three columns described below. Each section header also identifies that section's look back period (7-day look-back, 14-day look-back, etc.)

Column 1 - MDS 3.0 Item Location and Item Description

This column identifies the MDS 3.0 item location by section letter, item number and description of the MDS item. A notation of Cognitive Performance Scale (CPS) or the Brief Interview for Mental Status (BMIS) indicates the MDS item is associated with the BIMS severity score. A notation of Restorative Nursing in this column indicates the MDS item is used in the count of Restorative Nursing programs in the PDPM system.

Column 2 – PDPM Payment Categories Impacted

This column identifies any PDPM payment categories impacted by the MDS item. Additionally, there may be informational data in a particular area denoted by *Informational Only*.

Column 3 - Minimum Documentation and Review Standards Required Within the Specified Observation Period

This column provides an overview of any requirements for minimum documentation required to support the MDS responses. The column may also contain additional information that may aid the user in correctly providing supporting documentation for the MDS item.

All federal and state requirements must be met. Should state requirements be more stringent, they will supersede the federal requirements for the *minimum* documentation standard. It is the responsibility of the provider to be in compliance with both the federal and state requirements.

RAI Manual, page 5-2:
State Requirements: Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of State RAI Coordinators.)
This document represents the established MDS requirements for the State of Maine

MaineCare Benefits Manual, Section 67, Chapter III,
16.2.3 Quality review of the MDS process**:**
5. "Verified Case Mix Group Record" is a NF's completed MDS assessment form, which has been determined to accurately represent the resident's clinical condition, during the MDS assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM payment 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)	*~Special Care High* *~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation of active diagnosis of coma or persistent vegetative state documented by a physician, nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws, that is applicable during the 7-day look-back period. • The care plan must also describe the specific care needs of the resident due to this condition . ***Does NOT include:*** • Resident in advanced stages of progressive neurologic disorders (i.e. Alzheimer's).
B0700 Makes Self Understood (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Observations and interviews with family and/or speech pathologist that were used to justify the coding on the MDS must be documented in the medical record. • Documentation of resident's degree of impairment, ability 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, over all shifts. • Consistency between interdisciplinary team notes. ***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) **C0300 A,B,C** Temporal Orientation (BIMS) **C0400 A,B,C** Recall (BIMS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Validation of completion of interview items C0200, C0300 A, B, C, and C0400 A, B, and C at Z0400 dated on or before the ARD and within the 7-day observation period **OR** Documentation that the resident interview of BIMS items was completed preferably the day before or day of the ARD.
C0700 Short-Term Memory (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** Documentation to determine the resident's short-term memory status by requesting that staff from each shift validate resident's response to an event 5 minutes after it occurred. See RAI Manual, Section C for instructions.
C1000 Cognitive Skills for Daily Decision Making (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation by direct-care staff across **all shifts** within the 7-day look-back period demonstrating the degree of compromised decision-making about tasks of everyday living, including choosing clothing, knowing when to go to meals, using environmental cues to organize and plan, seeking information from others to plan the day. • Consistency between all interdisciplinary team notes. ***Does include:*** • Choosing clothing. • Knowing when to go to meals. • Using environmental cues to organize and plan (e.g. clocks, calendars). • Seeking information from others to plan the day. • Acknowledging the need to use appropriate assistive equipment (i.e. walker). • Awareness of strengths and limitations to regulate the day's events ***Does NOT include:*** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section D: Mood ***(14-day look back)***		
D0150A-I, Column 2 Resident Mood Interview (Symptom Frequency)	*~Special Care High* *~Special Care Low* *~Clinically Complex*	***Does require:*** • Validation of completion of items D0200 A-I at Z0400 dated on or before the ARD and within the 14-day observation period **OR** documentation of the Resident Mood Interview (PHQ-2-9) within the look back period.
D0500A-J, Column 2 Staff Assessment of Resident Mood (Symptom Frequency)	*~Special Care High* *~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of "scripted interviews...across all shifts with staff who know the resident best," which must include date of the interview, names of staff interviewed, their responses & name of staff performing the interviews, within the look back period. for each applicable item D0500 A-J. • If family member(s) or significant other(s) were interviewed, the date the interview was conducted, dates of family member(s) or significant other(s) observations and the frequency reported for each applicable item at D0500 A-J.
Section E: Behavior ***(7-day look back)***		
E0100A Hallucinations	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • **Example(s) and date(s)** of a resident's perception of the presence of something that is not actually there within the 7-day look-back period. May include auditory, visual, tactile, olfactory, or gustatory false sensory perceptions that occur in the absence of any real stimuli. ***Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis.*** • ***Review Steps for Assessment, page E-2 regarding review of medical record, staff interviews and observations of the resident during other structured interviews.*** ***Does include:*** • Auditory, visual or involving smells, tastes, or touch.
E0100B Delusions	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • **Example(s) and date(s)** of a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary, • ***Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply.*** • ***Review Steps for Assessment, page E-2 regarding review of medical record, staff interviews and observations of the resident during other structured interviews.*** ***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*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • **Example(s) and date(s)** of resident's physical behavioral symptoms directed toward others, ***Does include:*** • Hitting, kicking, pushing, scratching, grabbing, abusing others sexually. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section E: Behavior ***(7-day look back)***		
E0200B (code 2 or 3) Verbal Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • **Example(s) and date(s)** of resident's verbal behavioral symptoms directed toward others, ***Does include:*** • Threatening others, screaming at others, cursing at others. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0200C (code 2 or 3) Other Behavioral Symptoms <u>*not*</u> *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • **Example(s) and date(s)** of resident's other behavioral symptoms NOT directed toward others. ***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. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0800 (code 2 or 3) Rejection of Care	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • **Example(s) and date(s)** of resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's values, preferences or goals; ***Does include:*** • Behaviors that interrupt or interfere with the delivery of receipt of care including: verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care. • Hindering the delivery of care by disrupting the usual routine or process by which care is given. • Exceeding the level or intensity of resources that are usually available for the provision of care. • ***Review Steps for Assessment, page E-15 regarding review of medical record, staff interviews*** • ***Review the medical record to find out whether the care rejection behavior was previously addressed and documented in discussions or in care planning with the resident, family, or significant other and determined to be an informed choice consistent with the resident's values, preferences, or goals; or whether that the behavior represents an objection to the way care is provided, but acceptable alternative care and/or approaches to care have been identified and employed.*** ***Does NOT include:*** • Behaviors that have already been addressed and determined to be consistent with resident's values, preferences or goals. • Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section E: Behavior *(7-day look back)*		
E0900 (code 2 or 3) Wandering	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • **Example(s) and date(s)** of resident's moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction; • Care plans should consider the impact of wandering on resident safety and disruption to others and should be focused on minimizing these issues. (RAI Manual Section E) ***Does NOT include:*** • Pacing (repetitive walking with a driven/pressured quality) within a constrained space. • Traveling via a planned course to another specific place (dining room or activity).

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section GG: Functional Abilities and Goals Look-back period for Section GG (Admission) First three days of the stay. Look-back period for OBRA/Interim ARD plus 2 previous calendar days.		
GG0130A Self-Care: 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 Tube feedings and parenteral nutrition are not considered when coding this activity.	*~Extensive Services* *~Special Care High* *~Special Care Low* *~Clinically Complex* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation *during* the observation period to accurately capture the resident's usual performance. • Initials and dates to authenticate the medical record entries including signatures and titles to authenticate initials per episode occurrence. • Documentation must include information on how the determination of "usual performance" was made. • The key for coding Section GG must include all the MDS options and be equivalent to the intent and definition of the MDS key. • Key definitions must align with the definition in the RAI manual and must be available to the RN Reviewer and understood by facility staff. • Self-Care and Mobility definitions must include all tasks and components related to the specific activity. • If using narrative notes to support Section GG, each occurrence must include the specific activity. Wording must be equivalent to MDS key definitions for example "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". • Facilities utilizing one designated documentation collection tool should note corrections or references to additional documentation on that tool. • **RAI Manual, page 2-11: Interdisciplinary Team (IDT)** is a group of professional disciplines that combine knowledge, skills, and resources to provide the greatest benefit to the resident. • 42 CFR 483.21(b)(2) A comprehensive care plan must be (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, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s). • During the IDT meeting, facilities must determine usual performance based on the data gathered, document the IDT decision, and enter into the medical record on or prior to the completion date at Z0500.. • The IDT meeting note must be clear as to who participated in the meeting and decisions reached for each Section GG item. • **RAI Manual, page 2-34:** While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan. • All documentation to be considered for the review must be clearly identified and presented to the reviewer in an organized manner representing how the usual performance was determined. • Documentation must be maintained as part of the permanent original legal medical record and be readily accessible during the review. • Corrections must be made in accordance with the Medical Record Correction Policy. • A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence. Coding of a dash is not to be confused with coding "10" which means the resident was not able to attempt the activity due to environmental limitations; or code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
GG0130C Self-Care: Toileting Hygiene Managing clothing and perineal cleansing that takes place before and after the use of the toilet, commode, bedpan or urinal.		
GG0170B Mobility: Sit to Lying The ability to move from sitting on side of bed to lying flat on the bed**.**		
GG0170C Mobility: Lying to sitting on the side of the bed The ability to move from sitting on the side of the bed and with no back support.		
GG0170D Mobility: Sit to stand The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.		
GG0170E Mobility: Chair/bed to chair transfer The ability to transfer to and from a bed to a chair (or wheelchair).		
GG0170F Mobility: Toilet transfer The ability to get on and off a toilet or commode.		

SUPPORTIVE DOCUMENTATION GUIDELINES

		Does NOT include: • Individuals hired, compensated or not, by individuals 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. • Use of a dash when other coding is applicable (07, 09, 10, 88).

DEFINITION OF USUAL PERFORMANCE:

A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, **record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance but rather record the resident's usual performance**. (RAI Manual, page GG-11)

MDS 3.0 Item Location and Item Description	***PDPM payment 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* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of a toileting program trial that includes an individualized, resident-centered toileting program of at least **3 days of toileting patterns** with prompting to toilet and a **documented response to the trial toileting program** since the most recent admission/entry or reentry, or since urinary incontinence was first noted in the facility. • Following program trial and response, documentation of a current toileting program being used to manage urinary continence during the 7-day look back period must include: 1) implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern; 2) documentation that the program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, and a written report; and 3) documentation of resident's response to the toileting program by a licensed nurse **during the observation period**. • Systematic toileting program that is being managed 4 or more days of the 7-day look back period. ***Does include:*** • Program if only used by day (when the resident does not want to be awakened at night). ***Does NOT include:*** • Less than 4 days of a systematic toileting program. • Simply tracking of urinary continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.
H0500 Bowel Toileting Program (Restorative Nursing)	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of implementation of an individualized, resident-specific bowel toileting program **based on an assessment of the resident's unique bowel pattern**. • Documentation that the individualized program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; **AND** • Documentation of resident's response to the toileting program by a licensed nurse **during the observation period**. ***Does NOT include:*** • Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section I: Active Diagnoses *(7-day and 60-day look back)*		
Active Diagnosis Definition: A physician-documented diagnosis (physician, nurse practitioner, physician assistant, or clinical nurse specialist) 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. Simply listing a disease/diagnosis on the resident's medical record problem list is not sufficient for determining active or inactive status. • Requires documentation related to necessary care, monitoring, interventions, symptoms, or risks related to the diagnosis. (specifics are often found in the care plan) There are two look-back periods for this section: 1) Diagnosis identification (Step 1) is a 60-day look back period. 2) Diagnosis status: Active (Step 2) is a 7-day look back period (except for I2300 UTI, which does not use the active 7-day look back period). ***Does include:*** • *Functional limitations* – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis. • *Nursing monitoring* – 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.		
I2000 Pneumonia	*~Special Care High* *~Clinically Complex*	***See active diagnosis definition*** ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization without active treatment during the observation period. • Pneumonitis.
I2100 Septicemia	*~Special Care High*	***See active diagnosis definition*** **Does include:** • Sepsis, if the conditions below are met. • For sepsis to be considered septicemia, there needs to **be inflammation due to sepsis and evidence of a microbial process**. If the medical record reflects inflammation due to sepsis and evidence of a microbial process, code I2100, Septicemia. If the medical record does not reflect inflammation due to sepsis and evidence of a microbial process, enter the sepsis diagnosis and ICD code in item I8000, Additional Active Diagnoses. **Does not include:** • A hospital discharge note referencing septicemia during hospitalization without active treatment during the observation period. • Urosepsis as a standalone diagnosis without additional information to support a diagnosis of sepsis or septicemia.
I2900 Diabetes Mellitus (DM)	*~Special Care High*	***See active diagnosis definition*** ***Does include:*** • Diabetic Retinopathy. • Diabetic Nephropathy. • Diabetic Neuropathy.
I4400 Cerebral Palsy	*~Special Care Low*	***See active diagnosis definition*** ***Does require:*** • Nursing Function Score less than or equal to 11.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section I: Active Diagnoses (7-day and 60-day look back)		
I4900 Hemiplegia/ Hemiparesis	*~Clinically Complex*	***See active diagnosis definition*** ***Does require:*** • Nursing Function Score less than or equal to 11. ***Does include:*** • Left or right sided paralysis. • Must include reference to CVA to show a neurological deficit ***Does NOT include:*** • Left or right sided *weakness without reference to a neurological deficit*.
I5100 Quadriplegia	*~Special Care High*	***See active diagnosis definition*** ***Does require:*** • Nursing Function Score less than or equal to 11. • Physician documentation of an injury to the spinal cord that causes total paralysis of all four limbs (arms and legs) and is not the result of another condition. • Quadriplegia must be a primary diagnosis of complete paralysis (spinal cord injury), not the result of another condition. Reference to the original accident/injury, must be documented in the resident's record ***Does NOT include:*** • Functional quadriplegia. • Complete immobility due to severe physical disability or frailty that extends to all limbs. • Spastic quadriplegia, secondary to cerebral palsy should *not* be coded as quadriplegia.
I5200 Multiple Sclerosis (MS)	*~Special Care Low*	***See active diagnosis definition*** ***Does require:*** • Nursing Function Score less than or equal to 11.
I5300 Parkinson's Disease	*~Special Care Low*	**See Active Diagnosis Definition.** ***Does Require:*** • Nursing Function Score less than or equal to 11. ***Does include:*** • Paralysis agitans. • Shaking palsy. ***Does NOT include:*** • Parkinsonism and Parkinson's Syndrome
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease	*~Special Care High*	**See Active Diagnosis Definition**. ***Does include:*** • Chronic bronchitis. • Restrictive lung diseases (such as asbestosis, pulmonary fibrosis, etc.). • Emphysema ***Does NOT include:*** • Obesity hypoventilation syndrome. • Chronic lung disease(s) may be coded at I6200 OR I8000 but may not be coded at both.
I6300 Respiratory Failure	*~Special Care Low*	**See Active Diagnosis Definition.** • I6300 Respiratory Failure may not be also coded under I6200.

SUPPORTIVE DOCUMENTATION GUIDELINES

I0020/I0020B and J2100

Completion of the following 2 items is required in order to produce a full HIPPS code and thus categorize into a nursing category. When these items are completed, the software will produce a full HIPPS code that can then be used by the facility to determine nursing category.
Failure to complete these items will result in an inaccurate nursing-only PDPM classification or will be categorized as BC1 due to the inability to classify the assessment or tracking form.

I0020/I0020B	Indicate the resident's primary medical condition category: The diagnosis recorded here should be the primary diagnosis for the resident at the time of the MDS assessment completion when completed for OBRA assessments.
J2100	Recent Surgery Requiring Active SNF Care: If neither Yes nor No is appropriate (per guidance in the RAI Manual), code 8/Unknown.

MDS 3.0 Item Location and Item Description	***PDPM Payment Categories Impacted***	***Minimum Documentation and Review Standards Required Within the Specified Observation Period***
Section J: Health Conditions *(7-day look back)*		
J1100C Shortness of Breath or Trouble Breathing When Lying Flat (case mix review of this item as a payment item for the Special Care High payment group)	*~Special Care High*	***The resident should not be placed in distress to assess this condition.*** ***Does require:*** • Documentation of the presence of, or observation of shortness of breath or trouble breathing, including symptoms experienced, when lying flat during the observation period and/or Documentation indicating resident's avoidance of lying flat due to shortness of breath including interventions applied to avoid shortness of breath while lying flat during the 7-day look-back period. • Interview the resident about shortness of breath, as needed to confirm shortness of breath. Many residents, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms. • Documentation of staff interview on all shifts regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath. Case mix nurses are looking for documentation to support a greater amount of care as suggested by a higher payment group or case mix index (CMI) • Coding of I6200 COPD on the MDS (required for Special Care High payment group) • Evidence of active care, usually on the care plan with documentation that specific care was provided, on the treatment administration record, or documentation within the clinical record, within the 7-day look back related to COPD and J1100C to ensure direct care staff understand resident's specific care needs
J1550A Fever	*~Special Care High*	***Does require:*** • Fever of 2.4 degrees F. above the baseline. • Documentation to support the resident's elevated temperature meets the facility policy definition of being above baseline, within the 7-day look back period. "Baseline temperature must be established before the ARD" in accordance with the specific facility's policy/protocol. ***Does include:*** • A temperature of 100.4 degrees F. on admission (prior to the establishment of a baseline temperature).
J1550B Vomiting	*~Special Care High*	***Does require:*** • Documentation of regurgitation of stomach contents. • Documented occurrence(s) within the 7-day look-back period

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section K: Swallowing/Nutritional *(7-day look back)* *(K0300 only; 30-day and 180-day look back)*		
K0300 (code 1 or 2) Weight Loss	*~Special Care High*	***Does require:*** • Documentation of resident's weight both 30 days and 180 days prior to the current weight during the observation period. • Documentation supporting the expressed goal for the physician-prescribed weight loss regimen in the medical record. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. ***Does include:*** • Mathematical rounding. • Planned or unplanned. • Weight loss via a physician-prescribed weight loss regimen.
K0520A Parenteral / IV Feeding	*~Special Care High* ***~Special Care Low***	***Does require:*** • Documentation that includes any and all nutrition and hydration received by the nursing home resident during the observation period either at the nursing home, at the hospital, as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration. • Consistency with physician orders (time, type, amount, rate of administration) progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • A person-centered care plan to prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance and to address the underlying cause or causes of any current dehydration, as well as monitoring for potential side effects and effectiveness of Parenteral/IV feeding. • A periodic evaluation of the appropriateness of the care plan approach. • Supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need, including but not limited to supporting lab work, clinical signs and symptoms, malnutrition, etc. • Documentation indicating reason nutrition/hydration needs are not able to be achieved and maintained by oral intake. ***Does include:*** • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently. • IV fluids running at KVO (keep vein open). • IV fluids contained in IV piggybacks. • Hypodermoclysis and sub-q ports in hydration therapy. • IV fluids administered for the purpose of "prevention" of dehydration if specifically documented for nutrition and/or hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record. ***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.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section K: Swallowing/Nutritional *(7-day look back)* *(K0300 only; 30-day and 180-day look back)*		
K0520B Feeding Tube	*~Special Care High* ***~Special Care Low***	***Does require:*** • Documentation must support the *presence* of a nasogastric or abdominal feeding tube, during the 7-day look-back period (Column 2). (K0520B) • Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B. • Inconsistency between physician orders, progress notes, interdisciplinary notes, treatment records, and the person-centered care plan require documentation that discuss the inconsistencies. ***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. • Evidence in the clinical record includes time, type, amount and rate of administration.
K0710A3 Proportion of Total Calories the Resident Received Through Parenteral or Tube Feeding Column 3 - **During Entire 7 days**	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation to support the proportion of calories actually received for nutrition and/or hydration through tube feeding during the entire 7-day observation period. See example in the RAI Manual page K-16. • Documentation of intake records to determine actual caloric intake through oral intake. *For residents receiving both oral 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 each day within observation period. 2) Calories oral feeding provided each day within observation period. 3) Percent of total calories provided by tube feeding within the observation period.
K0710B3 Average Fluid Intake Per Day by IV or Tube Feeding Column 3 **- During Entire 7 days**	*~Special Care High* *~Special Care Low*	***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). ***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.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions ***(7-day look back)***		
M0300B1 Stage 2 **M0300C1** Stage 3 **M0300D1** Stage 4 **M0300F1** Unstageable Due to Slough/Eschar	*~Special Care Low*	***Does require:*** • Documentation of pressure ulcer(s)/injury within the observation period must include but is not limited to; identification of wound as a pressure ulcer, location, and description aligning with RAI description requirements. • Documentation must include a complete history of pressure ulcer(s)/injury when the reported stage is numerically higher than the current stage and description. • For each pressure ulcer, there must be documentation by RN or MD that includes the deepest anatomical stage, and description including location, dimensions, drainage, tissue type and color, etc. within the 7-day observation period. Do not reverse or back-stage. Consider current and historical levels of tissue involvement. Definitions, care planning, assessment and coding tips are in Section M of the RAI Manual. The ulcer would continue to be referred to according to the highest stage documented in the history of the ulcer. • Documentation of a healing pressure ulcer/injury(s) must include descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, identification of the wound as a pressure ulcer, etc.) within the 7-day observation period; OR • A validated pressure ulcer healing tool may be used. ***Does NOT include:*** • Pressure ulcers/injuries that are healed during the look-back period. • A pressure ulcer/injury surgically repaired with a flap or graft. • If pressure is NOT the primary cause. • Oral mucosal ulcers caused by pressure (reported at L0200C). • Skin tears, tape burns, moisture associated skin damage or excoriation.
M1030 Venous/Arterial Ulcers	*~Special Care Low*	***Does require:*** • Documentation of the venous/arterial ulcer must include but is not limited to; identification of the wound as a venous/arterial ulcer, location and description aligning with RAI description requirements. • Documentation must include a description of the ulcer such as location, dimensions, drainage, tissue color, etc. The presence of an ulcer related to impaired circulation must be made by an RN or physician, within the 7-day look-back period. The specific type of vascular ulcer (i.e. venous or arterial) must be determined by a physician. There must be a diagnosis of PVD or PAD, as appropriate. ***Does NOT include:*** • Pressure ulcers/injuries coded in M0210 through M0300.
M1040A Infection of the Foot	*~Special Care Low*	***Does require:*** • Documentation of signs and symptoms of infection of the foot. ***Does include:*** • Cellulitis. • Purulent drainage. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0300.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
M1040B Diabetic Foot Ulcer	*~Special Care Low*	***Does require:*** • Documentation of diabetic foot ulcer during the observation period must include but is not limited to identification of the wound as a diabetic foot ulcer, location and description. • Documentation of unhealed/healing diabetic ulcer of the foot by a RN or physician, within the 7-day look-back period. The type of ulcer must be determined by a physician. Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot). Do not include pressure ulcers that occur on residents with diabetes mellitus here. ***Does include:*** • Ulcers caused by neuropathic and small blood vessel complications of diabetes. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0300. • Pressure ulcers/injuries that occur on the heel of a diabetic resident.
M1040C Other Open Lesion on the Foot, (e.g. cuts, fissures)	*~Special Care Low*	***Does require:*** • Documentation of open lesion during the observation period must include but is not limited to location and appearance within the 7-day look back.. • Documentation that the lesion is open during observation period. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0300. • Open lesions to ankle.
M1040D Open Lesions Other Than Ulcers, Rashes, Cuts	*~Clinically Complex*	***Does require:*** • Documentation indicating the lesion is **open** with description of the area, including location and appearance, within the 7-day look-back **and** a Physician-documented diagnosis of the related disease/condition. • Documentation that the lesion is open during the observation period. ***Does include:*** • Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts and vesicles, should be coded in this item. ***Does NOT include:*** • Pressure ulcers/injury(s), venous or arterial ulcers, diabetic foot ulcers, skin tears, cuts, abrasions, or rashes.
M1040E Surgical Wound	*~Clinically Complex*	***Does require:*** • Description of the surgical wound must include but is not limited to identification of the wound as a surgical wound, location and description aligning with RAI description requirements. ***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/injury(s) 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/injury(s) that have been surgically debrided.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions ***(7-day look back)***		
M1040F Burn	*~Clinically Complex*	***Does require:*** • Description of the second- or third-degree burn must include but is not limited to degree, type, cause, location and description, during the 7-day observation period. • Documentation of the original burn, including the degree of the burn as determined by a RN or physician. and evidence of treatment to the burn within the look back period. ***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).
M1200A Pressure Reducing Device/*chair* **M1200B** Pressure Reducing Device/*bed*	*~Special Care Low*	***Does require:*** • Documentation of use of equipment aimed at reducing pressure away from areas of high risk during the observation period. • A physician order, facility policy OR signed attestation from administrator or DON identifying the facility's use of pressure reducing/relieving/redistributing mattresses on each resident's bed including documentation of manufacturer recommendations for maintenance with evidence of follow through. • Must be included in the care plan • There must be evidence of delivery within the 7-day look back. ***Does include:*** • Foam, air, water, gel, or other cushioning placed on chair, wheelchair or bed. • Pressure relieving, reducing, redistributing devices. ***Does NOT include:*** • Eggcrate cushions of any type. • Doughnut or ring devices in chairs or wheelchairs. • A physician order for a pressure relieving device without documentation of implementation is not sufficient for supporting documentation.
M1200C Turning/ Repositioning Program	*~Special Care Low*	***Does require:*** • add info from RAI • Documentation of interventions and frequency of program. (Program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs). • The turning/repositioning program must be specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees), the frequency (e.g., every 2 hours) and evidence the intervention was performed. • Evaluation by the licensed nurse describing the resident's response to the program within the observation period.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions ***(7-day look back)***		
M1200E Pressure Ulcer/injury Care	*~Special Care Low*	***Does require:*** • Documentation of intervention(s) for treating pressure ulcers/injuries identified at M0300B, C, D, and F during the observation period. • Physician's order for treatment and documentation of delivery of any intervention for treating pressure ulcers ***Does include:*** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT). • Hydrotherapy.
M1200F Surgical Wound Care	*~Clinically Complex*	***Does require:*** • Documentation of the intervention for treating or protecting any type of surgical wound identified at M1040E during the observation period. • Physician's order for treatment and documentation of delivery of any intervention for treating surgical wounds coded in M1040E is required. ***Does include:*** • Topical cleansing. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. • Pressure ulcers/injuries that require surgical intervention for closure (flap and/or graft coverage). ***Does NOT include:*** • Post-operative care following eye or oral surgery. • Surgical debridement of pressure ulcer/injury. • Observation "only" of the surgical wound.
M1200G Application of Non-surgical Dressings; Other Than to Feet	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet during the observation period. • Requires physician order for treatment and documentation of delivery at least once during the 7-day look- back period. ***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/injury(s) other than to foot; use ulcer/injury care (M1200E). • Self-Adhesive bandages (e.g.Band-Aids). • Wound closure strips.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
M1200H Application of Ointments/ Medications Other Than to Feet	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of application of ointments/medications (used to treat a skin condition) other than to feet during the observation period. • Requires physician's order for treatment **and** documentation of delivery within the 7-day look-back period. ***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/injury(s); use pressure ulcer/injury care (M1200E). • Ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).
M1200I Applications of Dressings to Feet	*~Special Care Low*	***Does require:*** • Documentation of dressing changes to the feet (with or without topical medication) during the observation period. • Interventions to treat any foot wound or ulcer **other than a pressure ulcer/injury during the observation period.** • Physician's order for treatment and documentation of delivery of interventions to treat any foot wound or ulcer other than pressure ulcer. ***Does NOT include:*** • Dressing application to the ankle (The ankle is not considered part of the foot). • For dressings to pressure ulcers/injuries on the foot; use pressure ulcer/injury care (M1200E).
Section N: Medications *(7-day look back)*		
N0350A Days of Insulin Injections	*~Special Care High*	***Does require:*** • Documentation must be consistent with physician orders and insulin administration records. • Documentation must include the number of days that insulin injections were received by the resident. ***Does include:*** • For residents with a subcutaneous insulin pump, this includes the number of days the resident actually required a subcutaneous injection to restart the subcutaneous insulin pump.
N0350B Days of Orders for Insulin	*~Special Care High*	***Does require:*** • Documentation must include the number of days that the insulin orders changed during the observation period. ***Does include:*** • Sliding scale order that is new, discontinued, or is the first sliding scale order. ***Does NOT include:*** • A sliding scale dosage schedule that is written to cover different dosages depending on lab values and the dose was administered based on the current sliding scale guidelines.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0110 Special Treatments	***Informational Only***	***Does include:*** • Special treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. • Code for Items "while a resident" ONLY. ***Does NOT include:*** • Services provided solely in conjunction with a surgical procedure (pre- and post-operative) or diagnostic procedure, such as IV medications or ventilators. • Surgical procedures including routine pre- and post-operative procedures.
O0110A1 Chemotherapy	*~Clinically Complex*	***Does require:*** • Documentation of administration of any type of chemotherapy agent (anticancer drug), during the observation period given by any route for the sole purpose of cancer treatment. • A current physician's order for chemotherapy is required. • Documentation must indicate that the resident actually received the chemotherapy and not just left the building (or remained in the building) with the intent to receive chemotherapy. • Documentation of any type of chemotherapy agent administered as an antineoplastic, aimed at destruction (the killing) of malignant cells, given by any route for cancer treatment **AND** a documented diagnosis of cancer. ***Does NOT include:*** • ***IV administered during chemotherapy.*** • ***IV medication administered during chemotherapy.*** • ***Blood transfusions administered during chemotherapy.*** • Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer are not coded in this item, as they are *not considered chemotherapy for the purpose of coding the MDS*.
O0110B1 Radiation	*~Special Care Low*	***Does require:*** • Documentation of administration of radiation therapy inside or outside of facility. • Documentation must indicate that the resident actually received the radiation and not just left the facility (or remained in the building) with the intent to receive the radiation. ***Does include:*** • Intermittent radiation therapy. • Radiation administered via radiation implant.
O0110C1 Oxygen Therapy	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. • Supporting diagnosis. • • Current physician order is required. ***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.
O0110E1 Tracheostomy Care	*~Extensive Services*	***Does require:*** • Physician order and documentation of cleansing of the tracheostomy and/or cannula, whether tracheostomy care is performed by resident or facility staff. ***Does include:*** • Changing a disposable cannula. • Resident performs his/her own tracheostomy care. • Laryngectomy tube care.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0110F1 Ventilator or Respirator	*~Extensive Services*	***Does require:*** • Documentation to support use of any type of *closed-system mechanical ventilator* devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item; closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (nasally or orally intubated) as well as residents with a tracheostomy. A resident being weaned off a ventilator within the last 14 days should be coded here. • The type of ventilator device and frequency used during the observation period. ***Does include:*** • Any resident being weaned off the ventilator or respirator during the observation period. • Any resident who was weaned from the respirator or ventilator in the last 14 days. ***Does NOT include:*** • Times when used as a substitute for BiPAP or CPAP.

O0110H1 IV Medications	*~Clinically Complex*	***Does require:***
		• Documentation of a physician's order and administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port during the observation period.
		
		Does include:
		• Epidural, intrathecal, and baclofen pumps.
		• When coding epidural, intrathecal or baclofen pumps, documentation must include:
		  • Physician's order supporting an epidural pump,
		  • documentation the epidural pump is being managed by nursing, **and**
		  • documentation that includes, but not limited to, medication effectiveness and side effects/effects of current dose
		• Additives such as electrolytes and insulin, which are added to the residents' 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.

O0110I1 Transfusions	*~Clinically Complex*	***Does require:*** • Documentation of the administration of blood or any blood products directly into the bloodstream while a resident in the facility and within the 14-day look back period. • Documentation must indicate that the resident actually received the transfusion and not just left the building (or remained in the building) with the intent to receive a transfusion. • ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0110J1 Dialysis	*~Special Care Low*	***Does require:*** • Documentation of the administration of peritoneal or renal dialysis that occurred inside or outside the facility. • Documentation must indicate that the resident actually received the dialysis and not just left the building (or remained in the building) with the intent to receive dialysis. • Documentation of a Physician's order and delivery of peritoneal or renal dialysis in the nursing facility or at another facility. ***Does include:*** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). • Resident performing his/her own dialysis. ***Informational:*** *IV, IV medication and blood transfusion administered during dialysis are considered part of the dialysis procedure and are NOT to be coded under items K0510A (Parenteral/IV feeding), O0100H (IV medications), or O0100I (Transfusions).*
O0110M1 Isolation or Quarantine for Active Infectious Disease	*~Extensive Services*	***Code for "Single Room Isolation" only when all four of the following conditions are documented in the medical record:*** 1. Resident has an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. Transmission-based precautions (contact, droplet, and/or airborne) must be in effect. **Standard Precautions Include**: • Hand hygiene compliance • Glove use • Masks • Eye protection • Gowns 3. Resident is in a room alone because of active infection and cannot have a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. Must remain in room. All services must be brought to the resident (e.g. rehabilitation, activities, dining, etc.) ***Does Require:*** • Active physician order to include diagnosis, type of isolation, and need for a private room. • Documentation supporting infectious disease (symptomatic, have a positive test, and are in the contagious stage). • Documentation of highly transmissible or epidemiologically significant pathogens acquired by physical contact, airborne or droplet transmission. ***Does NOT include:*** • Standard precautions. • History of infectious disease. • Urinary tract infections. • Encapsulated pneumonia. • Wound infections. • Cohorting with roommate.

SUPPORTIVE DOCUMENTATION GUIDELINES

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs Therapies *(7-day look back)*		
O0400D2 Respiratory Therapy	*~Special Care High*	***Does require:*** • Only medically necessary therapies that occurred after admission/readmission to the facility were: 1) Ordered by a physician (or other licensed professional as allowed by state law) based on a qualified therapist's assessment and treatment plan. 2) Physician order that includes a statement of treatment specific to the resident's needs, i.e. frequency, duration, and scope of treatment. 3) Documented in the resident's medical record. 4) Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective. • Therapy services may occur inside or outside the facility. • Documentation of *actual* direct minutes on a daily/shift/occurrence basis. Documentation of number of days respiratory therapy was administered for a total of at least 15 minutes/24hours in the 7-day look-back period • Documentation of minutes that the respiratory therapist or respiratory nurse spends with the resident conducting the actual respiratory therapy treatment including the set-up and removal of treatment equipment. • Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. • A respiratory assessment pre and post treatment that includes but is not limited to the following: heart rate, respiratory rates, breath sounds, the direct care minutes, and toleration. • Documentation of a change in condition requiring RN/Respiratory Therapist intervention, e.g. exacerbation of a chronic respiratory condition or onset of a new respiratory condition to show the medical necessity of skilled respiratory assessment. • Associated initials/signature(s) on a daily basis to support the total number of minutes of respiratory therapy provided. • Respiratory evaluation during the observation period by a respiratory therapist or a trained respiratory nurse. • Documentation that the respiratory nurse (licensed nurse) has been trained in the modalities provided through specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws. Documentation that services were provided by qualified personnel (RAI Manual, Appendix A). Qualified "professional" means registered nurse or respiratory therapist. ***Does include:*** • Coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc. ***Does NOT include:*** • Treatment for less than 15 direct minutes per day. • Metered-dose and/or dry powder inhalers. • Time a resident spends self-administering a nebulizer treatment without direct supervision of the respiratory therapist or respiratory nurse.

Maine Documentation Guidelines

MDS 3.0 Item Location and Item Description	*PDPM Payment Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(7-day look back)*		
O0500A-J Restorative Nursing Program Days	*~Rehabilitation* *~Impaired Cognition* *~Behavior Problems* *~Reduced Physical Function*	***Does require:*** • Documentation of actual direct minutes on a daily/shift/occurrence basis for each program provided within a 24-hour period. • Associated initials/signature(s) on a daily basis to support the total number of minutes of restorative nursing program(s) provided. • Each program must be individualized to the resident's needs, planned, monitored, evaluated, and documented. • Time must be documented separately for each restorative program. • Documentation must include the five criteria to meet the definition of a restorative nursing program: 1) Measurable objectives and interventions must be documented in the care plan and in the medical record; **and** 2) Evaluation of the program by a licensed nurse. (For the MDS Validation Review, reassess progress, goals and duration/frequency of each program within the observation period.); **and** 3) Staff trained in the proper techniques; **and** 4) Supervised by licensed nurse; **and** 5) No more than 4 residents per supervising helper or caregiver. • Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device and reposition the limb in correct alignment within the observation period. ***Does include:*** • An evaluation of the program written by the CNA and co-signed by a licensed nurse once the purpose and objectives have been established (contingent upon state Nurse Practice Act and any other applicable state laws). • ADL documentation may be reviewed in conjunction with restorative programs to confirm delivery of program. The facility is responsible for ensuring that **all documentation** to support the coding is present, accurate and available for review. ***Does NOT include:*** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • For both active and passive range of motion, movement by a resident that is incidental to care does not count as part of a formal restorative nursing program. • Treatment for less than 15 direct minutes per day.
*******O0500A (Passive Range of Motion) and O0500B (Active Range of Motion) count as one service even if both are provided.*** *******O0500D (Bed Mobility) and O0500F (Walking) count as one service even if both are provided.***		
Section Z: Assessment Administration		
Z0400	Signature of Persons Completing the Assessment of Entry/Death Reporting	***Does require:*** • All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed and the date completed. • If a staff member cannot sign Z0400 on the same day that they completed a section or portion of a section, when the staff member signs, use the date the item originally was completed. • Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a subset of items within a section should identify which item(s) they completed within that section.

Maine Documentation Guidelines

Z0500	Signature of RN Assessment Coordinator Verifying Assessment Completion	**Does require:** • Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. • For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date must be equal to or later than the latest date at Z0400. • Clarifying documentation dated after the Z0500 date will not be accepted as supporting documentation.

Maine Case Mix Quality Review Audit Protocol

Basis for decisions for Case Mix Quality Review Audits

- ❑ Maine Documentation Guidelines
  - Documentation guidelines that define the supporting documentation necessary to verify a PDPM item(s)
  - Maine uses PDPM Nursing Group for Long-Term Care payment group determination, effective 1/1/25.
- ❑ MaineCare Benefits Manual Section 67, Chapter II and Chapter III
- ❑ Current Resident Assessment Instrument (RAI) Manual
- ❑ It is the responsibility of the facility to read and understand the complete guidelines and manuals

Case Mix Quality Review Protocol

- ❑ At the time of entrance to facility conference
  - Request current census with payer source, alphabetical order preferred
  - Private workspace with access to electrical outlets
- ❑ Establish electronic connections to access facility software (username and password)
- ❑ The facility must provide a liaison to assist with medical records during the review process.
- ❑ The facility will have two options for providing documentation for the MDS remote quality review:
  - Direct network access to facility software in which the facility provides a username and password, with read-only access to software preferred.
  - Provision of hard copy of *all* documentation directly to reviewer via secure fax.
- ❑ The facility will have two options for providing documentation for the MDS on-site quality review:
  - Direct network access to facility software in which the facility provides a username and password, with read-only access to software preferred.
  - Provision of hard copy of *all* documentation directly to reviewer. The facility is responsible for ensuring data backup and security measures are in place to avoid inadvertent deletion of any records.
- ❑ Explain remote or on-site review process, as applicable
  - Provide list of requested medical records to the facility
  - Case Mix requests timely access to records and access to all resident medical records as needed to confirm supporting documentation
- ❑ Frequency of case mix quality review audits
  - Each Medicare/Medicaid certified facility is reviewed every 3-8 months, with an average of 6 months.
- ❑ Sample payer source selection
  - 24% sample of residents who have MaineCare as a payer source
- ❑ Facilities with an error rate of 34% or greater will be placed in sanctions as follows:
  - 2% sanction for error rate 34% or greater and less than 37%
  - 5% sanction for error rate 37% or greater and less than 41%
  - 7% sanction for error rate 41% or greater and less than 45%
  - 10% sanction for error rate 45% or greater
  - 10% sanction if requested reassessments not completed within 14k calendar days
- ❑ Office of MaineCare Services / Case Mix Team to determine choice of on-site vs. remote review
- ❑ Allow time for questions
  - Facility Administrator, Director of Nursing, MDS Coordinator or designee, Medical Records and any other staff of facility choice are encouraged to participate
  - Records will be reviewed using established means of communication established at entrance.
  - Facility to provide liaison throughout the review to assist with questions and location of documents
- ❑ Exit Conference
  - Exit conference is provided following the completion of the review
  - Preliminary findings will be reported including the number of assessments reviewed, percentage of payment errors, and specific details about all errors.
  - A list of resident records reviewed (sample list) will be present with the exit conference form.

- No supporting documentation will be accepted after the closing of the exit conference
- Any number of staff can attend the exit conference, the meeting may not be recorded
- All staff in attendance must sign the exit conference form
- Signature on the exit conference form confirms the facility has *received* the audit findings
- Time is allowed for questions
- For remote reviews
    - Sample list of resident records reviewed is provided
    - Exit Conference scheduled via Teams or Zoom
    - Signed exit conference forms must be returned to the reviewer electronically or by fax, in a timely manner.

Correction Protocol

- ❑ Payment errors and Documentation errors on the MDS must be corrected in the database by completing a modification or significant correction to a prior assessment (quarterly or comprehensive), within 14 days of the exit conference.
- ❑ If an assessment is submitted to CMS and CMS does not have authority to receive that assessment, a Manual Deletion form must be completed and submitted to the State RAI Coordinator by encrypted email or certified mail. The Manual Deletion may also be completed on the iQIES website. These manual deletion requests are checked for accuracy and sent by certified mail or via iQIES to be manually deleted from the CMS database.
- ❑ New information, not included in the original assessment, may not be added to an MDS modification, after review by a case mix nurse. If new information is to be added, a significant correction to a prior (quarterly or comprehensive) assessment, with a new ARD, must be completed.
- ❑ Facility-identified errors must be completed within 14 days of the discovery of the error, as documented in the clinical record.
- ❑ Any corrections made in the medical record, including but not limited to, the Activities of Daily Living (ADL) documentation must have an associated note of explanation for each correction.
- ❑ If a significant error on the MDS is discovered in a record after submission to the QIES ASAP system, modification or inactivation procedures must be followed as directed in the RAI manual.
- ❑ Improper or illegible corrections in the medical record, such as a write-over, will not be accepted for the Case Mix quality review audit.
- ❑ All documentation, paper or electronic, including corrections, must be part of the original legal medical record.
- ❑ All MDS coding questions shall be referred to the State RAI Coordinator or a case mix quality review nurse.
- ❑ **Only MDS that have been submitted and accepted into the database will be considered for case mix review.**

Case Mix Informal Review Protocol

- ❑ Appeal process
    - Within 60 calendar days of receipt of the exit conference, the facility may submit a written request for an Informal Review to the Associate Director of Compliance.
    - MaineCare Associate Director of Compliance will assign a staff member to review the original case mix audit results as part of the informal review process.
    - Designee will render a written decision when the review is complete.
    - Corrections must be completed for resident records not being appealed.
    - If the facility disagrees with the Office of MaineCare Services informal review decision, the facility can submit a request for an administrative hearing within 60 calendar days of receipt of the Informal Review decision.
    - The Administrative Hearings Unit will respond to the request for Administrative Hearing.

Sanction Protocol

- ❑ Rate setting will send out a letter that will alter the facilities rate of reimbursement, based on the sanction amount.
- ❑ The sanction affects the direct care rate only
- ❑ Adjustment impacts the facility reimbursement rate for one quarter (three months)