

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received *or performed* during the specified time periods.

O0110: Special Treatments, Procedures, and Programs

Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

O0110. Special Treatments, Procedures, and Programs			
Check all of the following treatments, procedures, and programs that were performed			
	a. On Admission	b. While a Resident	c. At Discharge
a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B			
b. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 14 days</i>			
c. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C			
	↓	Check all that apply ↓	↓
Cancer Treatments			
A1. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>		<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>		<input type="checkbox"/>
A10. Other	<input type="checkbox"/>		<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Treatments			
C1. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>		<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>		<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>		<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>		<input type="checkbox"/>
D3. As needed	<input type="checkbox"/>		<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G1. Non-invasive Mechanical Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>		<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>		<input type="checkbox"/>

O0110: Special Treatments, Procedures, and Programs (cont.)

Other			
H1. IV Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>		<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>		<input type="checkbox"/>
H4. Anticoagulant	<input type="checkbox"/>		<input type="checkbox"/>
H10. Other	<input type="checkbox"/>		<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J1. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>		<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>		<input type="checkbox"/>
K1. Hospice care		<input type="checkbox"/>	
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		<input type="checkbox"/>	
O1. IV Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>		<input type="checkbox"/>
O3. Midline	<input type="checkbox"/>		<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>		<input type="checkbox"/>
None of the Above			
Z1. None of the above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Item Rationale

Health-related Quality of Life

- The treatments, procedures, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

Planning for Care

- Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.
- Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks.

O0110: Special Treatments, Procedures, and Programs (cont.)

Steps for Assessment

1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the *assessment period defined for each column*.

Coding Instructions for Column *a. On Admission*

Check all treatments, procedures, and programs received by, performed on, or participated in by the resident on days 1–3 of the SNF PPS Stay starting with A2400B. If no treatments, procedures, or programs were received or performed in the 3-day assessment period, check Z, None of the above.

Coding Instructions for Column *b. While a Resident*

Check all treatments, procedures, and programs *that the resident* received or performed *after* admission/entry or reentry to the facility and within the *last 14 days*. If no *treatments, procedures or programs were received by, performed on, or participated in by the resident within the last 14 days or since admission/entry or reentry*, check Z, **None of the above**.

Coding Instructions for Column *c. At Discharge*

Check all treatments, procedures, and programs received *by, performed on, or participated in* by the resident *in the last 3 days of the SNF PPS Stay ending with A2400C. If no treatments, procedures or programs were received by, performed on, or participated in by the resident in the 3-day assessment period, check Z, None of the above.*

Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- **O0110A1, Chemotherapy**

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should **not** be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS. IVs, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0520A (Parenteral/IV), O0110H (IV Medications), or O0110I (Transfusions).

00110: Special Treatments, Procedures, and Programs (cont.)

Example: *Resident* J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After *their* cancer treatment, *Resident* J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

- **00110A2, IV**

Check if chemotherapy was administered intravenously.

- **00110A3, Oral**

Check if chemotherapy was administered orally (e.g., pills, capsules, or liquids the patient swallows). This sub-element also applies if the chemotherapy is administered through a feeding tube/PEG (i.e., enterally).

- **00110A10, Other**

Check if chemotherapy was given in a way other than intravenously or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).

- **00110B1, Radiation**

Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

- **00110C1, Oxygen therapy**

Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes *their* own oxygen mask, cannula.

- **00110C2, Continuous**

Check if oxygen therapy was continuously delivered for 14 hours or greater per day.

- **00110C3, Intermittent**

Check if oxygen therapy was intermittent (i.e., not delivered continuously for at least 14 hours per day).

- **00110C4, High-concentration**

Check if oxygen therapy was provided via a high-concentration delivery system. A high-concentration oxygen delivery system is one that delivers oxygen at a concentration that exceeds a fraction of inspired oxygen FiO₂ of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow rate of 4 liters per minute).

A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and nonrebreather masks, face tents, venturi masks, aerosol masks, and high-flow cannula or masks).

O0110: Special Treatments, Procedures, and Programs (cont.)

These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO₂ of these systems exceeds 40%.

Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO₂ of greater than 40%.

- **O0110D1, Suctioning**

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs *their* own tracheal and/or nasopharyngeal suctioning.

- **O0110D2, Scheduled**

Check if suctioning was scheduled. Scheduled suctioning is performed when the resident is assessed as clinically benefiting from regular interventions, such as every hour or once per shift. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of facility-based clinical standards, protocols, and guidelines.

- **O0110D3, As needed**

Check if suctioning was performed on an as-needed basis, as opposed to at regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted or a sudden desaturation occurs from a mucus plug.

- **O0110E1, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs *their* own tracheostomy care. *This item includes laryngectomy tube care.*

- **O0110F1, Invasive Mechanical Ventilator (ventilator or respirator)**

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) **unable to support *their* own respiration** in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

Example: *Resident J* is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day *while a resident*, because of an irreversible neurological injury and inability to breathe on *their* own. O0110F1b should be checked, as *Resident J* is using an invasive mechanical ventilator because *they are* unable to initiate spontaneous breathing on *their* own and the ventilator is controlling *their* breathing.

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110G1, Non-invasive Mechanical Ventilator**

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support *their* own spontaneous respiration** by providing enough pressure when the individual inhales to keep *their* airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes *their* own BiPAP/CPAP mask/device.

- **O0110G2, BiPAP**

Check if the non-invasive mechanical ventilator support was BiPAP.

- **O0110G3, CPAP**

Check if the non-invasive mechanical ventilator support was CPAP.

- **O0110H1, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Lactated Ringers given IV *is* not considered *a* medication and should not be coded here. *Resources and tools providing information on medications are available in Section N of this manual (see the end of item N0415 following the Example).*

- **O0110H2, Vasoactive medications**

Check when at least one of the IV medications was an IV vasoactive medication.

- **O0110H3, Antibiotics**

Check when at least one of the IV medications was an IV antibiotic.

- **O0110H4, Anticoagulation**

Check when at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.

- **O0110H10, Other**

Check when at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110I1, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **O0110J1, Dialysis**

Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0520A (Parenteral/IV), O0110H (IV medications), or O0110I (transfusions). This item may be coded if the resident performs *their* own dialysis.

- **O0110J2, Hemodialysis**

Check when the dialysis was hemodialysis. In hemodialysis the patient's blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.

- **O0110J3, Peritoneal dialysis**

Check when the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) serves as a filter to remove the waste products and excess fluid from the blood.

- **O0110K1, Hospice care**

Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110M1, Isolation *or* quarantine for active infectious disease (does not include standard *body/fluid* precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for “single room isolation” only when all of the following conditions are met:

1. The resident has 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. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in *their* room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings <https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf

As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0110M for single room isolation since it is still being maintained while the resident is in the facility.

O0110: Special Treatments, Procedures, and Programs (cont.)

Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. The definition and criteria of "significant change of status" is found in Chapter 2, Section 2.6, 03. Significant Change in Status Assessment (SCSA) (A0310A = 04). Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident's plan of care will likely need to be completed.

- **O011001, IV Access**

Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or, in some instances, the measurement of central venous pressure.

- **O011002, Peripheral**

Check when IV access was peripheral access (catheter is placed in a peripheral vein) and remains peripheral.

- **O011003, Midline**

Check when IV access was midline access. Midline catheters are inserted into the antecubital (or other upper arm) vein and do not reach all the way to a central vein such as the superior vena cava.

- **O011004, Central (e.g., PICC, tunneled, port)**

Check when IV access was centrally located (e.g., PICC, tunneled, port).

- **O0110Z1, None of the above**

Code if none of the above treatments, procedures, or programs were received or performed by the resident.

O0110: Special Treatments, Procedures, and Programs (cont.)

Examples

1. Resident R, who was admitted five days ago, has advanced prostate cancer and is receiving radiation and docetaxel (IV) via a port in their right upper chest to treat their prostate cancer. They were admitted to the SNF following an inpatient stay for an acute pulmonary embolism.

Coding: Check boxes O0110A1a (Chemotherapy, On Admission), O0110A1b (Chemotherapy, While a Resident), and O0110A2a (IV, On Admission); O0110B1a (Radiation, On Admission) and O0110B1b (Radiation, While a Resident); and O0110O1a (IV Access, On Admission), O0110O1b (IV Access, While a Resident), and O0110O4a (Central, On Admission).

Rationale: The resident received intravenous therapy via a port (i.e., a central line in their right upper chest) and radiation during their first three days of their SNF PPS stay and while a resident.

2. Resident M was admitted to the SNF for rehabilitation following cardiac surgery three weeks ago. They have sleep apnea and require a CPAP device nightly. While in the SNF, the staff set up the humidifier element of the CPAP, and Resident M put on the CPAP mask prior to falling asleep each night through their discharge to home.

Coding: Check boxes O0110G1b (Non-invasive Mechanical Ventilator, While a Resident), O0110G1c (Non-invasive Mechanical Ventilator, At Discharge), and O0110G3c (CPAP, On Discharge).

Rationale: Resident M can breathe on their own but requires CPAP while sleeping to manage their sleep apnea. CPAP was used while a resident, including during the three-day discharge assessment period.

3. Resident D was admitted 10 days ago to the SNF for rehabilitation following spinal surgery. They have sleep apnea and require a CPAP device while sleeping. The staff set-up the water receptacle and humidifier element of the machine. Each night since admission, Resident D puts on the CPAP mask and starts the machine prior to falling asleep.

Coding: Check O0110G1a (Non-invasive Mechanical Ventilator, On Admission), O0110G1b (Non-invasive Mechanical Ventilator, While a Resident) and O0110G3a (CPAP, On Admission).

Rationale: Resident D can breathe on their own but requires CPAP while sleeping to manage their sleep apnea. CPAP was used while a resident, including during the three-day admission assessment period.

O0250: Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code

A. Did the resident receive the influenza vaccine *in this facility* for this year's influenza vaccination season?

0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received

B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

Month		Day		Year					

C. If influenza vaccine not received, state reason:

Enter Code

1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

Item Rationale

Health-related Quality of Life

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.

Planning for Care

- Influenza vaccines have been proven effective in preventing hospitalizations.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.
- Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so individuals cannot get influenza from the vaccine.
 - **Mild problems:** soreness, redness or swelling where the shot was given; hoarseness; sore, red or itchy eyes; cough; fever; aches; headache; itching; and/or fatigue. If these problems occur, they usually begin soon after the shot and last 1-2 days.
 - **Severe problems:**
 - Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.

O0250: Influenza Vaccine (cont.)

- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, influenza vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.
- People who are moderately or severely ill should usually wait until they recover before getting the influenza vaccine. People with mild illness can usually get the vaccine.
- Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.
- The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC:
<http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/index.html>

Steps for Assessment

1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if *they* received an influenza vaccine outside of the facility for this year's influenza vaccination season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.

O0250: Influenza Vaccine (cont.)

Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?

- **Code 0, no:** if the resident **did NOT receive the influenza vaccine in this facility** during this year's influenza vaccination season. Proceed to **If influenza vaccine not received, state reason** (O0250C).
- **Code 1, yes:** if the resident **did receive the influenza vaccine in this facility** during this year's influenza season. Continue to **Date influenza vaccine received** (O0250B).

Coding Instructions for O0250B, Date influenza vaccine received

- Enter the date that the influenza vaccine was received. Do not leave any boxes blank.
 - If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014 should be entered as 01-17-2014.
 - If the day only contains a single digit, then fill the first box of the day with the "0". For example, October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required.
 - A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box.

Coding Instructions for O0250C, If influenza vaccine not received, state reason

If the resident has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list:

- **Code 1, Resident not in this facility during this year's influenza vaccination season:** resident was not in this facility during this year's influenza vaccination season.
- **Code 2, Received outside of this facility:** includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.
- **Code 3, Not eligible—medical contraindication:** if influenza vaccine not received due to medical contraindications. Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination.
- **Code 4, Offered and declined:** resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination.

O0250: Influenza Vaccine (cont.)

- **Code 5, Not offered:** resident or responsible party/legal guardian not offered the influenza vaccine.
- **Code 6, Inability to obtain influenza vaccine due to a declared shortage:** vaccine is unavailable at this facility due to a declared influenza vaccine shortage.
- **Code 9, None of the above:** if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

Coding Tips and Special Populations

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.
- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available. *More information about when facilities must offer residents the influenza vaccine is available in 42 CFR 483.80(d), Influenza and pneumococcal immunizations, which can be found in Appendix PP of the State Operations Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf#page=708.*
- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza:
<http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>,
<http://www.cdc.gov/flu/weekly/usmap.htm>.
- Facilities can also contact their local health department website for local influenza surveillance information.
- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, in the event that a declared influenza vaccine shortage occurs in your geographical area, residents should still be vaccinated once the facility receives the influenza vaccine.
- A “high dose” inactivated influenza vaccine is available for people 65 years of age and older. Consult with the resident’s primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the resident.

O0250: Influenza Vaccine (cont.)

Examples

1. *Resident* J received the influenza vaccine in the facility during this year's influenza vaccination season, on January 7, 2014.

Coding: O0250A would be **coded 1, yes**; O0250B would be **coded 01-07-2014**, and O0250C would be skipped.

Rationale: *Resident* J received the vaccine in the facility on January 7, 2014, during this year's influenza vaccination season.

2. *Resident* R did not receive the influenza vaccine in the facility during this year's influenza vaccination season due to *their* known allergy to egg protein.

Coding: O0250A would be **coded 0, no**; O0250B is skipped, and O0250C would be **coded 3, not eligible-medical contraindication**.

Rationale: Allergies to egg protein is a medical contraindication to receiving the influenza vaccine, therefore, *Resident* R did not receive the vaccine.

3. *Resident* T received the influenza vaccine at *their* doctor's office during this year's influenza vaccination season. *Their* doctor provided documentation of receipt of the vaccine to the facility to place in *Resident* T's medical record. *They* also provided documentation that *Resident* T was explained the benefits and risks of the influenza vaccine prior to administration.

Coding: O0250A would be **coded 0, no**; and O0250C would be **coded 2, received outside of this facility**.

Rationale: *Resident* T received the influenza vaccine at *their* doctor's office during this year's influenza vaccination season.

4. *Resident* K wanted to receive the influenza vaccine if it arrived prior to *their* scheduled discharge on October 5th. *Resident* K was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, *Resident* K did not receive the influenza vaccine in the facility.

Resident K was encouraged to receive the influenza vaccine at *their* next scheduled physician visit.

Coding: O0250A would be **coded 0, no**; O0250B is skipped, and O0250C would be **coded 9, none of the above**.

Rationale: *Resident* K was unable to receive the influenza vaccine in the facility due to the fact that the facility did not receive its shipment of influenza vaccine until after *their* discharge. None of the codes in O0250C, **Influenza vaccine not received, state reason**, are applicable.

O0300: Pneumococcal Vaccine

O0300. Pneumococcal Vaccine

Enter Code

A. Is the resident's Pneumococcal vaccination up to date?

0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0400, Therapies

Enter Code

B. If Pneumococcal vaccine not received, state reason:

1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Item Rationale

Health-related Quality of Life

- Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly.
- Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case-fatality rates.
- Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia.

Planning for Care

- Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.
- Individuals living in nursing homes and other long-term care facilities with an identified increased risk of invasive pneumococcal disease or its complications, i.e., those 65 years of age and older with certain medical conditions, should receive pneumococcal vaccination.
- Conditions that increase the risk of invasive pneumococcal disease include decreased immune function; damaged or no spleen; sickle cell and other hemoglobinopathies; cerebrospinal fluid (CSF) leak; cochlear implants; and chronic diseases of the heart, lungs, liver, and kidneys, including dialysis, diabetes, alcoholism, and smoking.

Steps for Assessment

1. Review the resident's medical record to determine whether any pneumococcal vaccines have been received. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if *they* received any pneumococcal vaccines outside of the facility. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, ask the same question of the responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.

O0300: Pneumococcal Vaccine (cont.)

4. If pneumococcal vaccination status cannot be determined, administer the recommended vaccine(s) to the resident, according to the standards of clinical practice.
 - If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.
 - If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.
 - If the resident has a minor illness (e.g., a cold) check with the resident's physician before administering the vaccine.

Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date?

- **Code 0, no:** if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, **If Pneumococcal vaccine not received, state reason.**
- **Code 1, yes:** if the resident's pneumococcal vaccination status is up to date. Skip to O0400, **Therapies.**

Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason

If the resident has not received a pneumococcal vaccine, code the reason from the following list:

- **Code 1, Not eligible:** if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize.
- **Code 2, Offered and declined:** resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.
- **Code 3, Not offered:** resident or responsible party/legal guardian not offered the pneumococcal vaccine.

Coding Tips

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at <https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf>.
- "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.

For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at

- <https://www.cdc.gov/vaccines/schedules/hcp/index.html>
- <http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>
- <https://www.cdc.gov/pneumococcal/vaccination.html>

O0300: Pneumococcal Vaccine (cont.)

- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.

Examples

1. *Resident* L, who is 72 years old, received the PCV13 pneumococcal vaccine at *their* physician's office last year. *They* had previously been vaccinated with PPSV23 at age 66.
Coding: O0300A would be **coded 1, yes**; skip to O0400, Therapies.
Rationale: *Resident* L, who is over 65 years old, has received the recommended PCV13 and PPSV23 vaccines.
2. *Resident* B, who is 95 years old, has never received a pneumococcal vaccine. *Their* physician has an order stating that *they are* NOT to be immunized.
Coding: O0300A would be **coded 0, no**; and O0300B would be **coded 1, not eligible**.
Rationale: *Resident* B has never received the pneumococcal vaccine; therefore, *their* vaccine is not up to date. *Their* physician has written an order for *them* not to receive a pneumococcal vaccine, thus *they are* not eligible for the vaccine.
3. *Resident* A, who has congestive heart failure, received PPSV23 vaccine at age 62 when *they were* hospitalized for a broken hip. *They are* now 78 years old and *were* admitted to the nursing home one week ago for rehabilitation. *They were* offered and given PCV13 on admission.
Coding: O0300A would be **coded 1, yes**; skip to O0400, Therapies.
Rationale: *Resident* A received PPSV23 before age 65 years because *they have* a chronic heart disease and received PCV13 at the facility because *they are* age 65 years or older. *They* should receive another dose of PPSV23 at least 1 year after PCV13 and 5 years after the last PPSV23 dose (i.e., *Resident* A should receive 1 dose of PPSV23 at age 79 years, but is currently up to date because *they* must wait at least 1 year since *they* received PCV13).
4. *Resident* T, who has a long history of smoking cigarettes, received the pneumococcal vaccine at age 62 when *they were* living in a congregate care community. *They are* now 64 years old and *are* being admitted to the nursing home for chemotherapy and respite care. *They have* not been offered any additional pneumococcal vaccines.
Coding: O0300A would be **coded 0, no**; and O0300B would be **coded 3, Not offered**.
Rationale: *Resident* T received 1 dose of PPSV23 vaccine prior to 65 years of age because *they are* a smoker. Because *Resident* T is now immunocompromised, *they* should receive PCV13 for this indication. *They* will also need 1 dose of PPSV23 8 weeks after PCV13 and at least 5 years after *their* last dose of PPSV23 (i.e., *Resident* T is eligible to receive PCV13 now and 1 dose of PPSV23 at age 67).

O0400: Therapies

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

A. Speech-Language Pathology and Audiology Services

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date

- 3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days
4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

		-			-				
Month			Day			Year			

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

		-			-				
Month			Day			Year			

B. Occupational Therapy

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date

- 3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days
4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

		-			-				
Month			Day			Year			

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

		-			-				
Month			Day			Year			

O0400 continued on next page

O0400: Therapies (cont.)

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date

- 3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days
4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month		Day		Year					

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month		Day		Year					

D. Respiratory Therapy

Enter Number of Minutes

Enter Number of Days

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0400E, Psychological Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes

Enter Number of Days

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0400F, Recreational Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes

Enter Number of Days

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0420, Distinct Calendar Days of Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0400: Therapies (cont.)

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

Planning for Care

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

O0400: Therapies (cont.)

Steps for Assessment

1. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.
- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Skip the item if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes (individual plus concurrent plus group) during the last 7 days is 0, skip this item and leave blank.

O0400: Therapies (cont.)

- **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption, in cases where the resident discontinued and then resumed therapy.
- **Therapy End Date**—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. Enter dashes if therapy is ongoing.

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

Coding Tips and Special Populations

- **Therapy Start Date:**
 1. Look at the date at A1600.
 2. Determine whether the resident has had skilled rehabilitation therapy at any time from that date to the present date.
 3. If so, enter the date that the therapy regimen started; if there was more than one therapy regimen since the A1600 date, enter the start date of the most recent therapy regimen.
- Psychological Therapy is provided by any licensed mental health professional, such as psychiatrists, psychologists, clinical social workers, and clinical nurse specialists in mental health as allowable under applicable state laws. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item.

O0400: Therapies (cont.)

Minutes of Therapy

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.
- If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted, *except in the case of an interrupted stay*.
- *In the case of an interrupted stay, the therapy start date entered in O0400A5, O0400B5, and/or O0400C5 must reflect a date on or after the date in A2400B. Although the therapy start date occurred prior to the interrupted stay, the data specifications only accept a therapy start date that is on or after the date entered in A2400B.*
- The therapist's time spent on documentation or on initial evaluation is not included.
- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- Family education when the resident is present is counted and must be documented in the resident's record.
- Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.
- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.
- Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

O0400: Therapies (cont.)

- Set-up time shall be recorded under the mode for which the resident receives initial treatment when *they* receive more than one mode of therapy per visit.
 - Code as individual minutes when the resident receives only individual therapy or individual therapy followed by another mode(s);
 - Code as concurrent minutes when the resident receives only concurrent therapy or concurrent therapy followed by another mode(s); and
 - Code as group minutes when the resident receives only group therapy or group therapy followed by another mode(s).
- For Speech-Language Pathology Services (SLP) and Physical (PT) and Occupational Therapies (OT) include only skilled therapy services. Skilled therapy services **must** meet **all** of the following conditions (Refer to Medicare Benefit Policy Manual, Chapters 8 and 15, for detailed requirements and policies):
 - for Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation;
 - the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
 - the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
 - the services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
 - the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
 - the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable, and they must be furnished by qualified personnel.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the long-term care facility only if *they are* under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MDS.
- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.

O0400: Therapies (cont.)

- Record the actual minutes of therapy. **Do not round therapy minutes (e.g., reporting) to the nearest 5th minute.** The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.
- When therapy is provided, staff need to document the different modes of therapy and set up minutes that are being included on the MDS. It is important to keep records of time included for each. When submitting a part B claim, minutes reported on the MDS may not match the time reported on a claim. For example, therapy aide set-up time is recorded on the MDS when it precedes skilled therapy; however, the therapy aide set-up time is not included for billing purposes on a therapy Part B claim.
- For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:
 - the physician orders the therapy;
 - the physician's order includes a statement of frequency, duration, and scope of treatment;
 - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
 - the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
 - the services must be reasonable and necessary for treatment of the resident's condition.

Non-Skilled Services

- Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in item O0400 **Therapies**, even when performed by a therapist or an assistant.
- As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in item O0400 **Minutes**, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in Item 0400. These services should be documented in the resident's medical record.

O0400: Therapies (cont.)

- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in item O0400A, B, or C **Therapies**. The services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are **not** skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

Co-treatment

For Part A:

When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. All policies regarding mode, modalities and student supervision must be followed as well as all other federal, state, practice and facility policies. For example, if two therapists (from different disciplines) were conducting a group treatment session, the group must be comprised of two to six participants who were doing the same or similar activities in each discipline. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.

For Part B:

Therapists, or therapy assistants, working together as a "team" to treat one or more patients **cannot** each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for *their* services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both.

O0400: Therapies (cont.)

Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

Therapy Aides and Students

Therapy Aides

Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy) and should be coded under the appropriate mode for the skilled therapy (individual, concurrent, or group) in O0400. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available).

Therapy Students

Medicare Part A—Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant (**Federal Register**, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed.

Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

- Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:
 - The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
 - The practitioner is not engaged in treating another patient or doing other tasks at the same time.
 - The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician's service, not for the student's services.)
 - Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a qualified physical or occupational therapist.

O0400: Therapies (cont.)

Modes of Therapy

A resident may receive therapy via different modes during the same day or even treatment session. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look-back period for an MDS assessment).

Individual Therapy

The treatment of one resident at a time. The resident is receiving the therapist's or the assistant's full attention. Treatment of a resident individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count. For example, the speech-language pathologist treats the resident individually during breakfast for 8 minutes and again at lunch for 13 minutes. The total of individual time for this day would be 21 minutes.

When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals **and they are** able to immediately intervene/assist the student as needed.

Example:

- A speech therapy graduate student treats *Resident A* for 30 minutes. *Resident A*'s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or *Resident A*. *Resident A*'s therapy may be coded as 30 minutes of individual therapy on the MDS.

Concurrent Therapy

Medicare Part A

The treatment of 2 residents, who are not performing the same or similar activities, at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

O0400: Therapies (cont.)

When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy.; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

Medicare Part B

- The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment

Examples:

- A physical therapist provides therapies that are not the same or similar, to *Resident Q* and *Resident R* at the same time, for 30 minutes. *Resident Q*'s stay is covered under the Medicare SNF PPS Part A benefit. *Resident R* is paying privately for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - *Resident Q* received concurrent therapy for 30 minutes.
 - *Resident R* received concurrent therapy for 30 minutes.
- A physical therapist provides therapies that are not the same or similar to *Resident S* and *Resident T* at the same time, for 30 minutes. *Resident S*'s stay is covered under the Medicare SNF PPS Part A benefit. *Resident T*'s therapy is covered under Medicare Part B. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - *Resident S* received concurrent therapy for 30 minutes.
 - *Resident T* received group therapy (Medicare Part B definition) for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)

O0400: Therapies (cont.)

- An Occupational Therapist provides therapy to *Resident* K for 60 minutes. An occupational therapy graduate student who is supervised by the occupational therapist, is treating *Resident* R at the same time for the same 60 minutes but *Resident* K and *Resident* R are not doing the same or similar activities. Both *Resident* K and *Resident* R's stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - *Resident* K received concurrent therapy for 60 minutes.
 - *Resident* R received concurrent therapy for 60 minutes.

Group Therapy

Medicare Part A

The treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or assistant who is not supervising any other individuals.

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

Medicare Part B

The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

- When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:
- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.

O0400: Therapies (cont.)

Examples:

- A Physical Therapist provides similar therapies to *Resident W*, *Resident X*, *Resident Y* and *Resident Z* at the same time, for 30 minutes. *Resident W* and *Resident X*'s stays are covered under the Medicare SNF PPS Part A benefit. *Resident Y*'s therapy is covered under Medicare Part B, and *Resident Z* has private insurance paying for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - *Resident W* received group therapy for 30 minutes.
 - *Resident X* received group therapy for 30 minutes.
 - *Resident Y* received group therapy for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
 - *Resident Z* received group therapy for 30 minutes.
- *Resident V*, whose stay is covered by SNF PPS Part A benefit, begins therapy in an individual session. After 13 minutes the therapist begins working with *Resident S*, whose therapy is covered by Medicare Part B, while *Resident V* continues with *their* skilled intervention and is in line-of-sight of the treating therapist. The therapist provides treatment during the same time period to *Resident V* and *Resident S* for 24 minutes who are not performing the same or similar activities, at which time *Resident V*'s therapy session ends. The therapist continues to treat *Resident S* individually for 10 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - *Resident V* received individual therapy for 13 minutes and concurrent therapy for 24.
 - *Resident S* received group therapy (Medicare Part B definition) for 24 minutes and individual therapy for 10 minutes. (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- *Resident A* and *Resident B*, whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, *Resident A* and *Resident B* are joined by *Resident T* and *Resident E*, whose stays are also covered by Medicare Part A, and the therapist begins working with all of them on the same therapy goals as part of a group session. After 15 minutes in this group session, *Resident A* becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - *Resident A* received concurrent therapy for 30 minutes and group therapy for 15 minutes.
 - *Resident B* received concurrent therapy for 30 minutes and group therapy for 30 minutes.
 - *Resident T* received group therapy for 30 minutes.
 - *Resident E* received group therapy for 30 minutes.

O0400: Therapies (cont.)

Therapy Modalities

Only skilled therapy time (i.e., require the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS. The use and rationale for all therapy modalities, whether skilled or unskilled should always be documented as part of the resident's plan of care.

Dates of Therapy

A resident may have more than one regimen of therapy treatment during an episode of a stay. When this situation occurs the Therapy Start Date for the most recent episode of treatment for the particular therapy (SLP, PT, or OT) should be coded. When a resident's episode of treatment for a given type of therapy extends beyond the ARD (i.e., therapy is ongoing), enter dashes in the appropriate Therapy End Date. Therapy is considered to be ongoing if:

- The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
- The resident's SNF benefit exhausted and therapy continued to be provided, or
- The resident's payer source changed and therapy continued to be provided.

For example, *Resident N* was admitted to the nursing home following a fall that resulted in a hip fracture in November 2019. Occupational and Physical therapy started December 3, 2019. *Their* physical therapy ended January 27, 2020 and occupational therapy ended January 29, 2020. Later on during *their* stay at the nursing home, due to the progressive nature of *their* Parkinson's disease, *they were* referred to SLP and OT February 10, 2020 (*they* remained in the facility the entire time). The speech-language pathologist evaluated *them* on that day and the occupational therapist evaluated *them* the next day. The ARD for Resident N's MDS assessment is February 28, 2020. Coding values for *their* MDS are:

- O0400A5 (SLP start date) is 02102020,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 02112020,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 12032019, and
- O0400C6 (PT end date) is 01272020.

O0400: Therapies (cont.)

General Coding Example:

Following a stroke, *Resident F* was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/19 under Part A skilled nursing facility coverage. *They* had slurred speech, difficulty swallowing, severe weakness in both *their* right upper and lower extremities, and a Stage 3 pressure ulcer on *their* left lateral malleolus. *They were* referred to SLP, OT, and PT with the long-term goal of returning home with *their child and child's spouse*. *Their* initial SLP evaluation was performed on 10/06/19, the PT initial evaluation on 10/07/19, and the OT initial evaluation on 10/09/19. *They were* also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/13/19 was an appropriate ARD for *their* 5-Day assessment. During the look-back period *they* received the following:

Speech-language pathology services that were provided over the 7-day look-back period:

- Individual dysphagia treatments; Monday-Friday for 30 minute sessions each day.
- Cognitive training; Monday and Thursday for 35 minute concurrent therapy sessions and Tuesday, Wednesday and Friday 25 minute group sessions.
- Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day.

Coding:

O0400A1 would be **coded 190**; O0400A2 would be **coded 70**; O0400A3 would be **coded 75**; O0400A4 would be **coded 5**; O0400A5 would be **coded 10062019**; and O0400A6 would be **coded with dashes**.

Rationale:

Individual minutes totaled 190 over the 7-day look-back period $[(30 \times 5) + (20 \times 2) = 190]$; concurrent minutes totaled 70 over the 7-day look-back period $(35 \times 2 = 70)$; and group minutes totaled 75 over the 7-day look-back period $(25 \times 3 = 75)$. Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-2019, and dashes were used as the therapy end date value because the therapy was ongoing.

Occupational therapy services that were provided over the 7-day look-back period:

- Individual sitting balance activities; Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT each code the session as 30 minutes for each discipline).
- Individual wheelchair seating and positioning; Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions.

Coding:

O0400B1 would be **coded 113**, O0400B2 would be **coded 0**, O0400B3 would be **coded 80**, O0400B3A would be **coded 60**, O0400B4 would be **coded 5**, O0400B5 would be **coded 10092019**, and O0400B6 would be **coded with dashes**.

O0400: Therapies (cont.)

Rationale:

Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period $[(30 \times 2) + 23 + 18 + 12 = 113]$; concurrent minutes totaled 0 over the 7-day look-back period $(0 \times 0 = 0)$; and group minutes totaled 80 over the 7-day look-back period $(20 \times 4 = 80)$. Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-2019 and dashes were used as the therapy end date value because the therapy was ongoing.

Physical therapy services that were provided over the 7-day look-back period:

- Individual wound debridement followed by application of routine wound dressing; Monday the session lasted 22 minutes, 5 minutes of which were for the application of the dressing. On Thursday the session lasted 27 minutes, 6 minutes of which were for the application of the dressing. For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.
- Individual sitting balance activities; on Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT each code the session as 30 minutes for each discipline).
- Individual bed positioning and bed mobility training; Monday-Friday for 35 minutes each day.
- Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day.

Coding:

O0400C1 would be **coded 287**, O0400C2 would be **coded 100**, O0400C3 would be **coded 0**, O0400C3A would be **coded 60**, O0400C4 would be **coded 5**, O0400C5 would be **coded 10072019**, and O0400C6 would be **coded with dashes**.

Rationale:

Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period $[(30 \times 2) + (35 \times 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]$; concurrent minutes totaled 100 over the 7-day look-back period $(20 \times 5 = 100)$; and group minutes totaled 0 over the 7-day look-back period $(0 \times 0 = 0)$. Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2019, and dashes were used as the therapy end date value because the therapy was ongoing.

Respiratory therapy services that were provided over the 7-day look-back period:

- Respiratory therapy services; Sunday-Thursday for 10 minutes each day.

Coding:

O0400D1 would be **coded 50**, O0400D2 would be **coded 0**.

Rationale:

Total minutes were 50 over the 7-day look-back period $(10 \times 5 = 50)$. Although a total of 50 minutes of respiratory therapy services were provided over the 7-day look-back period, there were not any days that respiratory therapy was provided for 15 minutes or more. Therefore, O0400D equals **zero days**.

O0400: Therapies (cont.)

Psychological therapy services that were provided over the 7-day look-back period:

- Psychological therapy services were not provided at all over the 7-day look-back period.

Coding:

O0400E1 would be **coded 0**, O0400E2 would be **left blank**.

Rationale:

There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

Recreational therapy services that were provided over the 7-day look-back period:

- Recreational therapy services; Tuesday, Wednesday, and Friday for 30-minute sessions each day.

Coding:

O0400F1 would be **coded 90**, O0400F2 would be **coded 3**.

Rationale:

Total minutes were 90 over the 7-day look-back period ($30 \times 3 = 90$). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.

O0400: Therapies (cont.)

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies

Enter Number of Minutes

	1	9	0
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Enter Number of Minutes

		7	0
--	--	---	---

Enter Number of Minutes

		7	5
--	--	---	---

Enter Number of Minutes

			0
--	--	--	---

Enter Number of Days

5

A. Speech-Language Pathology and Audiology Services

- Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
- Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
- Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date

- 3A. Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days
- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
- Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

1	0	-	0	6	-	2	0	1	9
Month			Day			Year			

- 6. Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

-	-	-	-	-	-	-	-	-	
Month		Day		Year					

B. Occupational Therapy

Enter Number of Minutes

	1	1	3
--	---	---	---

Enter Number of Minutes

			0
--	--	--	---

Enter Number of Minutes

		8	0
--	--	---	---

Enter Number of Minutes

		6	0
--	--	---	---

Enter Number of Days

5

- Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
- Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
- Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date

- 3A. Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days
- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
- Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

1	0	-	0	9	-	2	0	1	9
Month			Day			Year			

- 6. Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

-	-	-	-	-	-	-	-	-	
Month		Day		Year					

O0400 continued on next page

O0400: Therapies (cont.)

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes

	2	8	7
--	---	---	---

Enter Number of Minutes

	1	0	0
--	---	---	---

Enter Number of Minutes

			0
--	--	--	---

Enter Number of Minutes

		6	0
--	--	---	---

Enter Number of Days

5

- Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
- Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
- Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date

- 3A. Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days
- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
- Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

1	0	-	0	7	-	2	0	1	9
Month			Day			Year			

- Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

-	-	-	-	-	-	-	-
Month		Day		Year			

D. Respiratory Therapy

Enter Number of Minutes

		5	0
--	--	---	---

Enter Number of Days

0

- Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0400E, Psychological Therapy
- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes

			0
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Enter Number of Days

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- Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0400F, Recreational Therapy
- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes

		9	0
--	--	---	---

Enter Number of Days

3

- Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0420, Distinct Calendar Days of Therapy
- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0420: Distinct Calendar Days of Therapy

O0420. Distinct Calendar Days of Therapy

Enter Number of Days

Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Item Rationale

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Coding Instructions:

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days. If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

- Example 1: Resident T received 60 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Resident T also received 45 minutes of occupational therapy on Monday, Tuesday and Friday during the last 7 days. Given the therapy services received by Resident T during the 7-day look-back period, item **O0420 would be coded as 4** because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Tuesday, Wednesday, and Friday).
- Example 2: Resident F received 120 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Resident F also received 90 minutes of occupational therapy on Monday, Wednesday and Friday during the last 7 days. Finally, Resident F received 60 minutes of speech-language pathology services on Monday and Friday during the 7-day look-back period. Given the therapy services received by Resident F during the 7-day look-back period, item **O0420 would be coded as 3** because therapy services were provided for at least 15 minutes on 3 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday).

O0425: Part A Therapies

Section O - Special Treatments, Procedures, and Programs

O0425. Part A Therapies

Complete only if A0310H = 1

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

A. Speech-Language Pathology and Audiology Services

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)
5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

B. Occupational Therapy

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)
5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

C. Physical Therapy

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)
5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

O0425: Part A Therapies (cont.)

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

Planning for Care

- *Except in the case of an interrupted stay*, code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist as allowable under state licensure laws) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.
- *In the case of an interrupted stay, code medically necessary therapies that occurred during the entire current Medicare Part A PPS stay that meet the above-noted criteria.*
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

O0425: Part A Therapies (cont.)

Steps for Assessment

1. Complete only if A0310H (Is this a SNF Part A PPS Discharge Assessment?) = 1, Yes.
2. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

NOTE: The look-back *period* for these items is the entire SNF Part A stay, starting at Day 1 of the Part A stay and finishing on the last day of the Part A stay. Once reported on the MDS, CMS grouping software will calculate the percentage of group and concurrent therapy, combined, provided to each resident as a percentage of all therapies provided to that resident, by discipline. If the combined amount of group and concurrent therapy provided, by discipline, exceeds 25 percent, then this would be deemed as non-compliance and a warning message would be received on the Final Validation Report.

Providers should follow the steps outlined below for calculating compliance with the concurrent/group therapy limit:

- Step 1: Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + O0425X3)
- Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2+O0425X3)
- Step 3: Concurrent/Group Ratio (Step 2 result/Step 1 result)
- Step 4: If Step 3 result is greater than 0.25, then the provider is non-compliant.

O0425: Part A Therapies (cont.)

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time. (For detailed definitions and examples of individual therapy, refer to O0400 above.)
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. (For detailed definitions and examples of concurrent therapy, refer to item O0400 above.)
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. (For detailed definitions and examples of group therapy, refer to item O0400 above.)
- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). Skip the item if none were provided. (For detailed definitions and examples of co-treatment, refer to item O0400 above.)
- **Speech-Language Pathology Days**—Enter the number of days speech-language pathology therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.

O0425: Part A Therapies (cont.)

- **Occupational Therapy Days**—Enter the number of days occupational therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.
- **Physical Therapy Days**—Enter the number of days physical therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.

Coding Tips and Special Populations

- For detailed descriptions of how to code minutes of therapy and explanation of skilled versus nonskilled therapy services, co-treatment, therapy aides and students, please refer to these topic headings in the discussion of item O0400 above.

Modes of Therapy

A resident may receive therapy via different modes during the same day or even treatment session. These modes are individual, concurrent and group therapy. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look-back period for an MDS assessment).

Individual Therapy

For a detailed definition and example of individual therapy, please refer to the discussion of item O0400 above.

O0425: Part A Therapies (cont.)

Concurrent Therapy

For a detailed definition and example of concurrent therapy, please refer to the discussion of item O0400 above.

Group Therapy

For a detailed definition and example of group therapy, please refer to the discussion of item O0400 above.

Therapy Modalities

For a detailed definition and explanation of therapy modalities, please refer to the discussion of item O0400 above.

General Coding Example:

Following a bilateral knee replacement, *Resident* G was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on Sunday 10/06/19 under Part A skilled nursing facility coverage. While in the hospital, *they* exhibited some short-term memory difficulties specifically affecting orientation. *They were* non-weight bearing, had reduced range of motion, and had difficulty with ADLs. *They were* referred to SLP, OT, and PT with the long-term goal of returning home with *their spouse*. *Their* initial SLP evaluation was performed on 10/06/19, and the OT and PT initial evaluations were done on 10/07/19. *They were* also referred to recreational therapy. *They were* in the SNF for 14 days and *were* discharged home on 10/19/2019. *Resident* G received the following rehabilitation services during *their* stay in the SNF.

Speech-language pathology services that were provided over the SNF stay:

- Individual cognitive training; six sessions for 45 minutes each day.
- Discharged from SLP services on 10/14/2019.

Coding:

O0425A1 would be **coded 270**; O0425A2 would be **coded 0**; O0425A3 would be **coded 0**; O0425A4 would be **coded 0**; O0425A5 would be **coded 6**.

Rationale:

Individual minutes totaled 270 over the stay (45 minutes × 6 days); concurrent minutes totaled 0 over the stay (0 × 0 = 0); and group minutes totaled 0 over the stay (0 × 0 = 0). Therapy was provided 6 days of the stay.

Occupational therapy services that were provided over the SNF stay:

- Individual ADL activities daily for 30 minutes each starting 10/08/19.
- Co-treatment: seating and transferring with PT; three sessions for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities: 10 sessions for 20 minutes each session in a group.

O0425: Part A Therapies (cont.)

- Discharged from OT services on 10/19/19.

Coding:

O0425B1 would be **coded 413**, O0425B2 would be **coded 0**, O0425B3 would be **coded 200**, O0425B4 would be **coded 53**, O0425B5 would be **coded 12**.

Rationale:

Individual minutes (including 53 co-treatment minutes) totaled 413 over the stay $[(30 \times 12) + 53 = 413]$; concurrent minutes totaled 0 over the stay $(0 \times 0 = 0)$; and group minutes totaled 200 over the stay $(20 \times 10 = 200)$. Therapy was provided 12 days of the stay.

Physical therapy services that were provided over the stay:

- Individual mobility training daily for 45 minutes per session starting 10/07/19.
- Group mobility training for 30 minutes Tuesdays, Wednesdays, and Fridays.
- Co-treatment seating and transferring for three sessions with OT for 7 minutes, 22 minutes, and 18 minutes.
- Concurrent therapeutic exercises Monday-Friday for 20 minutes each day.
- Discharged from PT services on 10/19/19.

Coding:

O0425C1 would be **coded 632**, O0425C2 would be **coded 200**, O0425C3 would be **coded 180**, O0425C4 would be **coded 47**, O0425C5 would be **coded 13**.

Rationale:

Individual minutes (including 47 co-treatment minutes) totaled 632 over stay $[(45 \times 13) + (7 + 22 + 18) = 632]$; concurrent minutes totaled 200 over the stay $(20 \times 10 = 200)$; and group minutes totaled 180 over the stay $(30 \times 6 = 180)$. Therapy was provided 13 days of the stay.

O0430: Distinct Calendar Days of Part A Therapy

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

Enter Number of Days

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Record the number of **calendar days** that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes since the start date of the resident's most recent Medicare Part A stay (A2400B)

Item Rationale

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes during the Part A SNF stay.

Coding Instructions:

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes during the SNF Part A stay (i.e., from the date in A2400B through the date in A2400C). If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding item O0430. Consider the following example:

Example: *Resident* T was admitted to the SNF on Sunday 10/06/18 and discharged on Saturday 10/26/18. *They* received 60 minutes of physical therapy every Monday, Wednesday, and Friday during the SNF stay. *Resident* T also received 45 minutes of occupational therapy every Monday, Tuesday, and Friday during the stay. Given the therapy services received by *Resident* T during the stay, item **O0430 would be coded as 12** because therapy services were provided for at least 15 minutes on 12 distinct calendar days during the stay (i.e., every Monday, Tuesday, Wednesday, and Friday).

O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prostheses care
<input type="checkbox"/>	J. Communication

Item Rationale

Health-related Quality of Life

- Maintaining independence in activities of daily living and mobility is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers/injuries.

Planning for Care

- Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
- A resident may be started on a restorative nursing program when *they are* admitted to the facility with restorative needs, but *are* not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

O0500: Restorative Nursing Programs (cont.)

Steps for Assessment

1. Review the restorative nursing program notes and/or flow sheets in the medical record.
2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period.
3. The following criteria for restorative nursing programs must be met in order to code O0500:
 - Measurable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
 - Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
 - Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
 - A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies or O0425, Part A Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies and O0425, Part A Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
 - This category does not include groups with more than four residents per supervising helper or caregiver.

O0500: Restorative Nursing Programs (cont.)

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** item O0400A or O0425A, **Occupational Therapy** item O0400B or O0425B, and **Physical Therapy** item O0400C or O0425C.
- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. For example, to check **Technique—Range of Motion [Passive]** item O0500A, 15 or more minutes of passive range of motion (PROM) must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift). However, 15-minute time increments cannot be obtained by combining 5 minutes of **Technique—Range of Motion [Passive]** item O0500A, 5 minutes of **Technique—Range of Motion [Active]** item O0500B, and 5 minutes of **Splint or Brace Assistance** item O0500C, over 2 days in the last 7 days.
- Review for each activity throughout the 24-hour period. **Enter 0**, if none.

Technique

Activities provided by restorative nursing staff.

- **O0500A, Range of Motion (Passive)**

Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

- **O0500B, Range of Motion (Active)**

Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Include active ROM and active-assisted ROM.

- **O0500C, Splint or Brace Assistance**

Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

O0500: Restorative Nursing Programs (cont.)

Training and Skill Practice

Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

- **O0500D, Bed Mobility**

Code activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning *themselves* in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500E, Transfer**

Code activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500F, Walking**

Code activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500G, Dressing and/or Grooming**

Code activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500H, Eating and/or Swallowing**

Code activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500I, Amputation/ Prosthesis Care**

Code activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

O0500: Restorative Nursing Programs (cont.)

- **O0500J, Communication**

Code activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Coding Tips and Special Populations

- For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance.
- For range of motion (active): any participation by the resident in the ROM activity should be coded here.
- For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures.
- For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device.
- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to be individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

O0500: Restorative Nursing Programs (cont.)

Examples

1. *Resident V* has lost range of motion in *their* right arm, wrist, and hand due to a cerebrovascular accident (CVA) experienced several years ago. *They have* moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to *their* right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to *their* right arm, wrist, and hand three times per day. The nurse's aides and *Resident V's spouse* have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented in *Resident V's* care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes (15 minutes to perform ROM exercises and 15 minutes to apply/remove the splint). The nurse's aides report that there is less resistance in *Resident V's* affected extremity when bathing and dressing *them*.

Coding: Both **Splint or Brace Assistance** item (O0500C), and **Range of Motion (Passive)** item (O0500A), would be **coded 7**.

Rationale: Because this was the number of days these restorative nursing techniques were provided.

2. *Resident R's* right shoulder ROM has decreased slightly over the past week. Upon examination and X-ray, *their* physician diagnosed *them* with right shoulder impingement syndrome. *Resident R* was given exercises to perform on a daily basis to help improve *their* right shoulder ROM. After initial training in these exercises by the physical therapist, *Resident R* and the nursing staff were provided with instructions on how to cue and sometimes actively assist *Resident R* when *they* cannot make the full ROM required by the exercises on *their* own. *Their* exercises are to be performed for 15 minutes, two times per day at change of shift in the morning and afternoon. This information is documented in *Resident R's* medical record. The nursing staff cued and sometimes actively assisted *Resident R* two times daily over the past 7 days.

Coding: **Range of motion (active)** item (O0500B), would be **coded 7**.

Rationale: Because this was the number of days restorative nursing training and skill practice for active ROM were provided.

O0500: Restorative Nursing Programs (cont.)

- Resident* K was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, *they* had difficulty moving *themselves* in bed and *were dependent* for transfers. To prevent further deterioration and increase *their* independence, the nursing staff implemented a plan on the second day following admission to teach *them* how to move *themselves* in bed and transfer from bed to chair using a trapeze, the bed rails, and a transfer board. The plan was documented in *Resident* K's medical record and communicated to all staff at the change of shift. The charge nurse documented in the nurse's notes that in the 5 days *Resident* K has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, *their* endurance and strength have improved, and *they* require only *substantial/maximal* assistance for transferring. Each day the amount of time to provide this nursing restorative intervention has been decreasing, so that for the past 5 days, the average time is 45 minutes.

Coding: Both **Bed Mobility** item (O0500D), **Transfer** item (O0500E), would be **coded 5**.

Rationale: Because this was the number of days that restorative nursing training and skill practice for bed mobility and transfer were provided.

- Resident* D is receiving training and skill practice in walking using a quad cane. Together, *Resident* D and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide *Resident* D with the instruction and guidance *they* need to achieve the goals. *They have* three scheduled times each day where *they* learn how to walk with *their* quad cane. Each teaching and practice episode for walking, supervised by a nursing assistant, takes approximately 15 minutes.

Coding: **Walking** item (O0500F), would be **coded 7**.

Rationale: Because this was the number of days that restorative nursing skill and practice training for walking was provided.

- Resident* J had a CVA less than a year ago resulting in left-sided hemiplegia. *Resident* J has a strong desire to participate in *their* own care. Although *they* cannot dress *themselves* independently, *they are* capable of participating in this activity of daily living. *Resident* J's overall care plan goal is to maximize *their* independence in ADLs. A plan, documented on the care plan, has been developed to assist *Resident* J in how to maintain the ability to put on and take off *their shirt* with no physical assistance from the staff. All of *their shirts* have been adapted for front closure with hook and loop fasteners. The nursing assistants have been instructed in how to verbally guide *Resident* J as *they* put on and takes off *their shirt* to enhance *their* efficiency and maintain *their* level of function. It takes approximately 20 minutes per day for *Resident* J to complete this task (dressing and undressing).

Coding: **Dressing or Grooming** item (O0500G), would be **coded 7**.

Rationale: Because this was the number of days that restorative nursing training and skill practice for dressing and grooming were provided.

O0500: Restorative Nursing Programs (cont.)

6. *Resident W*'s cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration attempts to promote *their* independence in feeding *themselves*, *they* will not eat unless *they are* fed.

Coding: Eating and/or Swallowing item (O0500H), would be **coded 0**.

Rationale: Because restorative nursing skill and practice training for eating and/or swallowing were not provided over the last 7 days.

7. *Resident E* has Amyotrophic Lateral Sclerosis. *They* no longer *have* the ability to speak or even to nod *their* head “yes” or “no.” *Their* cognitive skills remain intact, *they* can spell, and *they* can move *their* eyes in all directions. The speech-language pathologist taught both *Resident E* and the nursing staff to use a communication board so that *Resident E* could communicate with staff. The communication board has been in use over the past 2 weeks and has proven very successful. The nursing staff, volunteers, and family members are reminded by a sign over *Resident E*'s bed that they are to provide *them* with the board to enable *Resident E* to communicate with them. This is also documented in *Resident E*'s care plan. Because the teaching and practice using the communication board had been completed 2 weeks ago and *Resident E* is able to use the board to communicate successfully, *they* no longer receive skill and practice training in communication.

Coding: Communication item (O0500J), would be **coded 0**.

Rationale: Because the resident has mastered the skill of communication, restorative nursing skill and practice training for communication was no longer needed or provided over the last 7 days.