



**Detailed Guide
for
Completing the
Nursing Facility
LTC Medicaid Information
For MDS 3.0**

Item by Item

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Overview

This guide is to be used in conjunction with the Texas Medicaid & Healthcare Partnership (TMHP) Long-Term Care (LTC) Online Portal and the Federal Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) version 3.0 assessment. The entry of the Long-Term Care Medicaid Information (LTCMI) can ONLY occur after the submission of the Federal MDS 3.0 assessment and it has been made available on the TMHP LTC Online Portal. Once an assessment has been submitted to Federal CMS, it will take 24 to 48 hours before it is extracted and available on the LTC Online Portal for completion of the LTCMI. This document covers how to complete the LTCMI section of the assessment. How to complete all other assessment fields can be found on the Federal CMS website. www.cms.hhs.gov.

Coding Conventions

The following coding conventions should be used when preparing the LTCMI as follows:

- When completing hard copy assessments to be used for data entry, capital letters may be easiest to read. Print legibly.
- Dates - Where recording month, day, and year, enter two digits for the month and the day, and four digits for the year (mm/dd/yyyy). For example, the sixth of July in the year 2006 is recorded: 07/06/2006.
- Not all fields are always required. Some fields are conditionally required. Answers to various fields determine what downstream fields are required. Example: LAR Address information is only required if an answer of Yes is entered for “*Does the resident report having a legally authorized representative?*”
- Always choose the most appropriate response from the values provided in the LTC Online Portal. Values are provided here for reference only and may not be inclusive of all values.
- Responses on the LTCMI should not conflict with MDS Assessment.
- Assessment Reference Date (i.e A2300) establishes the endpoint for the look-back periods.

MDS Assessment Extraction – Awaiting LTC Medicaid Information

With MDS 3.0, Texas MDS assessments will be transmitted directly to the Federal MDS database and then will be copied to the State server for use by TMHP.

On the MDS assessment, the following values must be entered to allow the TMHP LTC Online Portal to extract the MDS assessment:

1. A0700 must contain either a “+” sign or the Medicaid number;
2. A0310A is coded as 01, 02, 03, 04, 05 or 06; and
3. A0100A is coded with the nursing facility’s National Provider Identifier (NPI) number.

If A0700, A0310A or A0100A in the MDS assessment has not been coded accurately, follow the process described in the Federal CMS RAI Manual, Chapter 5, and transmit a corrected MDS assessment to the

Federal MDS database. Check the MDS validation report to ensure the MDS assessment was accepted into the Federal MDS database.

Note: If all values are completed accurately, and after waiting 48 hours, the TMHP LTC Online Portal still does not reflect your assessment, contact Andy Alegria at Andy.Alegria@dads.state.tx.us or 512-438-2396 or Cheryl Shiffer at Cheryl.Shiffer@dads.state.tx.us or 210-619-8010 to determine if the MDS properly transmitted to the Federal MDS database.

Providers must utilize the TMHP LTC Online Portal to complete the LTCMI. Assessments needing the LTCMI completed can be located by using FSI (Form Status Inquiry) or Current Activity. Assessments with a status of "Awaiting LTC Medicaid Information" are those assessments that have been extracted from the state database and are ready for an LTCMI to be completed. An assessment is not processed for medical necessity (MN) determination until the LTCMI has been successfully submitted. Providers have the capability to delete any MDS assessment in a status of "Awaiting LTC Medicaid Information" if for some reason the provider does not want to submit the LTCMI. Details on utilizing FSI, Current Activity or deleting assessments can be found in the [LTC Online Portal Manual for Nursing Facility/Hospice Providers](#).

Before submitting the LTCMI

Health and Human Services Commission (HHSC) Medicaid Eligibility: The resident must meet the HHSC Medicaid Eligibility requirements in order for an assessment to successfully process and set to status "Processed/Complete". **Stop** and **initiate** the HHSC Medicaid Eligibility process if the resident does not have Medicaid Eligibility established and the process has not already been initiated. The medical necessity determined by the MDS is one of the requirements for the eligibility determination so continue the MDS process while eligibility is being established. The HHSC process can take up to 6 months. Every MDS assessment submitted, regardless of Type of Assessment (i.e. Admission, Quarterly, Annual, Significant Change in Status Assessment (SCSA), etc) checks for Medicaid Eligibility (ME) and Applied Income (AI). If an MDS assessment is processing and ME is not yet established by HHSC, the MDS assessment is set to status "Medicaid ID Pending" or "ME Pending" until HHSC has established ME. If an MDS assessment is processing and AI is not yet determined by HHSC, the MDS assessment is set to status "AI Pending" until HHSC has made a determination. MDS assessments are not processed until the HHSC Medicaid Eligibility approvals are completed. Once Medicaid Eligibility has been established, the assessment will attempt to process.

Admit and Discharge Forms: Don't forget any necessary 3618/3619 Admit forms that might be required. Some examples include: 1) If the MDS Type of Assessment A0310A is an Admission assessment, a 3618/3619 Admit form is required, and 2) If the client discharges to the hospital, upon readmission to the nursing facility, a 3618/3619 Admit form is required. If the resident is transferring from another facility, the discharging facility must submit a discharge form.

PASARR Screening: If the MDS Type of Assessment A0310A is an Admission assessment and at least one value from S2a - S2c on the LTCMI is a 'Y', then an MN approved PASARR Screening must be on file at TMHP prior to submitting the Admission assessment LTCMI on the portal. **Stop** and submit a PASARR Screening, if one is not already on file. PASARR Screenings are to be submitted prior to the MDS Admission assessment. If a PASARR Screening is not on file when one is required, the MDS admission assessment status will be set to "PASARR not found invalid form" and the assessment will not be processed. Additional PASARR Information can be found here: <http://www.dads.state.tx.us/providers/pasarr/index.html>

Assistance with the LTC Online Portal

Call **TMHP** at 1-800-626-4117, Option 1, for:

- Nursing Facility document completion – including Pre-admission Screening and Resident Review (PASARR) screening
- Rejection codes on the forms and assessments
- Questions about “Provider Action Required” status

Call **DADS Provider Claims Services (PCS)** at 1-512-438-2200, Option 1, for:

- Denials or pending denials of residents who have established prior permanent medical necessity
- If the Medicaid, Social Security Number (SSN) numbers are accurate, yet the status indicates “ID Invalid”.

How to **Prevent the Timing Out** of the TMHP LTC Online Portal LTCMI:

It is important to note that when completing the LTCMI, the portal will time-out after 20 minutes of no activity. To prevent this from happening, the nursing facility has the following options:

- Start and finish (submit or save as draft) the LTCMI within 20 minutes.
Click on a different tab of the assessment and then return to the LTCMI tab. This will reset the timer for another 20 minutes.

Section LTC MEDICAID INFORMATION

S1. Claims Processing Information

S1a. DADS Vendor/Site ID Number

This field should be auto populated based on the NPI number in field A0100A.

This field is not correctable on the TMHP LTC Online Portal.

If A0100A National Provider Identifier (NPI) is not correct on the MDS, then the NPI must be fixed at the Federal CMS level.

S1b. Contract/Provider Number

This field should be auto populated based on the NPI number in field A0100A.

This field is not correctable on the TMHP LTC Online Portal.

If an NPI has more than one contract/provider number associated with it, be sure the correct contract/provider number is selected from the drop-down box.

S1c. Service Group

This field is auto populated based on the user's LTC Online Portal logon credentials.

If the user is tied to a NF provider, the field will be auto populated with 1 for Nursing Facility.

If the user is tied to a Swing Bed provider, the field will be auto populated with 10 for Swing Bed.

This field is not correctable on the TMHP LTC Online portal.

If S1c. Service Group is inconsistent with A0200. Type of Provider, the following warning message will appear.

"The service group in the field S1c does not match the service group selected in field A0200" Should this message appear, click the 'OK' button to acknowledge.

S1d. Hospice Contract Number

Required field if O0100K. Hospice care column 2 "While a Resident" is checked.

Enter the Medicaid **hospice** provider **contract number** assigned by DADS.

This field is correctable.

Entering the hospice provider contract number in this field will allow the hospice provider to view the assessment submitted on their behalf by the nursing facility.

S1e. Purpose Code

Optional field.

Enter the value that corresponds to the appropriate response:

E. Missed Assessment

M. Coverage Code must be "P"

This field is not removable once a Purpose Code has been selected and the assessment successfully submitted on the TMHP LTC Online Portal.

Example:

Once a Purpose Code has been submitted, the assessment will always require a Purpose Code A provider can submit a Purpose Code M and correct it to an E if the resident does not meet the 3 month prior requirement.

A provider cannot submit a Purpose Code E and correct it to an M.
A provider can submit a blank Purpose Code and then correct to an E or M.

Purpose Code E - What is a Purpose Code E and how do you complete a Purpose Code E?

Important: Nursing Facilities SHOULD NOT modify an existing MDS LTCMI by entering a Purpose Code without careful consideration. If this is done, the existing MDS service period is cancelled and replaced with the Purpose Code E service period. All services previously billed and paid at the RUG level of the cancelled MDS will be recouped. The resident can no longer have a calculated RUG for the original service period.

There typically are three situations when a Minimum Data Set (MDS) Purpose Code E (PC E) should be submitted:

1. RUG Gap. Once the resident has been established on a RUG, a PC E will be needed if the next MDS assessment submission completely misses the anticipated assessment quarter. Each Z0500B (Signature of RN Assessment Coordinator Verifying Assessment Completion) establishes a 92-day period (Z0500B + 91 days), so the next assessment should be completed and submitted within the 92-day anticipated MDS assessment quarter following the 92-day span of the current MDS assessment.

- DADS will stop payment following 31 days after the first 91 days from the Z0500B for the current assessment, unless the next MDS has continued the cycle.
- The next MDS assessment will not be considered missed if it has a Z0500B date within the anticipated MDS assessment quarter and the LTCMI is completed on the LTC Online Portal within 91 days of the new MDS assessment Z0500B date.
 - If the new MDS assessment is submitted within the anticipated quarter and the LTCMI is completed within 91 days of the new Z0500B date, the gap following the 31 days and prior to the new Z0500B date will automatically be filled. A calculated RUG rate will be paid for the entire period in this situation.
 - If the new MDS is not submitted within the anticipated quarter or the LTCMI is not completed within 91 days of the Z0500B date, a gap will be created following the 31 days until the Z0500B date of the new assessment. Payment for this gap will be made at the PCE default rate once a PC E MDS is processed. To fill the gap, submit the appropriate off-cycle assessment (e.g., Quarterly, Annual) including the LTCMI by completing:
 - Field S1e field on the LTCMI completed as the PC E;
 - Missed Assessment Start Date (S1f); and
 - Missed Assessment End Date (S1g).

2. Missed Admission MDS. If a new resident is admitted to the facility and the admission assessment is submitted more than 91 days after Z0500B of that admission assessment, the admission assessment will have to be submitted as a PC E. Payment for this gap will be made at the PC E default rate. Submit the admission assessment including the LTCMI by completing:

- Field S1e field on the LTCMI completed as the PC E;
- Missed Assessment Start Date (S1f); and
- Missed Assessment End Date (S1g).

3. Late LTCMI for MDS Admission assessment. Any LTCMI that is completed more than 91 days after the Z0500B date of that assessment will require a PC E. Payment for this gap will be made at the PC E default rate and should be submitted with:

- Field S1e field on the LTCMI completed as the PC E;
- Missed Assessment Start Date (S1f); and
- Missed Assessment End Date (S1g).

Purpose Code M – A Purpose Code M should be submitted when Medicaid coverage is granted retroactively (up to three months prior) after the resident is certified for Medicaid. When there is an application for Medicaid the resident’s financial eligibility is considered and reviewed based on the month of application. If the resident is determined to be Medicaid eligible, the worker does a consideration on the three months prior to the application to determine if the resident may have been financially eligible at an earlier date. The Purpose Code M was designed to allow the provider to submit a MDS Purpose Code M to cover those 3 months so the payment could be made at a RUG value rather than the default PCE rate. The retroactive Medicaid is shown on the MESAV as a TP 14 Coverage Code P or TP 11 which is the 3 month prior for TP SSI Coverage.

To fill a period approved by the financial worker for dates prior to the application the provider has two options:

1. Submit an off-cycle MDS assessment including the LTCMI by completing

- Field S1e field on the LTCMI completed as the PC M;
- Missed Assessment or Prior Start Date (S1f); and
- Missed Assessment or Prior End Date (S1g).

2. Modify an earlier MDS that has not been used for the Medicaid cycle and complete the LTCMI as a PC M by completing

- Field S1e on the LTCMI completed as the PC M;
- Missed Assessment or Prior Start Date (S1f); and

- Missed Assessment or Prior End Date (S1g).

Correcting an LTCMI to include a Purpose Code E or M will void any prior service dates and change the MDS to be valid for the start to end date only. If payment has been made, recoupment will occur.

S1f. Missed Assessment or Prior Start Date

Required field if S1e. Purpose Code = E or M.
Enter the date in mm/dd/yyyy Format.
Date cannot be prior to September 1, 2008.
Field is correctable.

S1g. Missed Assessment End Date

Required field if S1e. Purpose Code = E or M.
Enter the date in mm/dd/yyyy format of the missed assessment or 3 month prior Retro Eligibility (Coverage code must be "P" end date).
Date cannot be greater than date of submission (i.e. today's date).
Field is correctable.

ENTRY TIP: To submit a PC E or M for one-day, the Missed Assessment Start and End Date must be the same date.

S2. PASARR Information

S2a. To your knowledge, does the resident have an intellectual disability?

Required field.
Enter the most appropriate response: Y = YES or N = NO.

S2b. To your knowledge, does the resident have a developmental disability?

Required field.
Enter the most appropriate response: Y = YES or N = NO.

S2c. To your knowledge, does the resident have a condition of mental illness according to the PASARR guidelines?

Required field.
Enter the most appropriate response: Y = YES or N = NO.

S2d. Is the resident a danger to himself / herself?

Required field.
Enter the most appropriate response: Y = YES or N = NO.
If unknown, then reply with N = NO.

S2e. Is the resident a danger to others?

Required field.

Enter the most appropriate response: Y = YES or N = NO.
If unknown, then reply with N = NO.

ENTRY TIP: If one value from S2a - S2c is a 'Y' and the Type of Assessment is an Admission, then an MN approved PASARR Screening must be on file. **Stop** and complete a PASARR Screening, prior to submitting this LTCMI, if a PASARR is not already on file at TMHP.

S2f. Are specialized services indicated?

Required field.

This field is disabled and unavailable for data entry.

Click the "Determine Specialized Services" button and this field will be auto populated with No or Yes.

S3. Physician's Evaluation & Recommendation

S3a. Do you have plans for the eventual discharge of this resident?

Required if Admission Assessment, SCSA or Recovery of Lost Payment (Purpose Code E).
Enter the most appropriate response: Y = YES or N = NO.

S3b. Rehabilitative Potential

Required if Admission Assessment, SCSA or Recovery of Lost Payment (Purpose Code E).
Enter the most appropriate response:

1 = good

2 = fair

3 = minimal

S3c. I hereby certify that this resident requires/continues to require nursing facility care.

Required if Admission Assessment, SCSA or Recovery of Lost Payment (Purpose Code E).
Enter the most appropriate response: Y = YES or N = NO.

S3d. MD/DO Last Name

Required field.

Enter the last name of the MD/DO.

S3e. MD/DO License #

Required field if S3g. MD/DO Military Spec Code # is not populated.

Enter the license number of the MD/DO.

This number is validated against Texas Medical Board records.

Physicians are not required to complete the RUG training.

S3f. MD/DO License State

Required field.

Enter the state in which the MD/DO is licensed.

S3g. MD/DO Military Spec Code #

Required field if S3e. MD/DO License # is not populated.
Enter the Military Spec Code number of the MD/DO.

S3h. MD/DO First Name

Required field if S3e License State is NOT Texas.
Enter the first name of the resident's MD/DO.
This information is used to mail MN determination letters.

S3i. MD/DO Address

Required field if S3e License State is NOT Texas.
Enter the street address of the resident's MD/DO.
This information is used to mail MN determination letters.

S3j. MD/DO City

Required field if S3e License State is NOT Texas.
Enter the city of the resident's MD/DO mailing address.
This information is used to mail MN determination letters.

S3k. MD/DO State

Required field if S3e License State is NOT Texas.
Enter the state of the resident's MD/DO mailing address.
This information is used to mail MN determination letters.

S3l. MD/DO ZIP code

Required field if S3e License State is NOT Texas.
Enter the ZIP code of the resident's MD/DO mailing address.
This information is used to mail MN determination letters.

S3m. MD/DO Phone

Optional field if S3e License State is NOT Texas.
Enter the phone number of the resident's MD/DO.
This information is used to contact MD/DO if necessary.

S4. Licenses

S4a. RN Coordinator Last Name

Required field.
Enter the last name of the RN Assessment Coordinator from Z0500A.

S4b. RN Coordinator License #

Required field.

Enter the license number of the RN Coordinator.

Licenses issued in Texas will be validated against the Texas BON (Board of Nursing).

Compact Licenses will be validated with the issuing state's nursing board.

This number is validated to ensure RUG training requirements have been met.

S4c. RN Coordinator License State

Required field.

Enter the state in which the RN Coordinator is licensed.

S5. Primary Diagnosis

S5a. Primary Diagnosis ICD Code

Required field.

Enter a valid ICD code for the resident's primary diagnosis.

This diagnosis should be the one that most significantly contributes to the resident's need for the services of a licensed nurse.

S5b. Primary Diagnosis ICD Code Description

Optional field.

Click the magnifying glass and the description will be auto populated based on the primary diagnosis ICD Code.

S6. Additional MN Information

S6a. Tracheostomy Care

This is a required field only available for data entry if O0100E. Tracheostomy care column 2 "While a Resident" is checked AND the resident is less than 22 years of age.

Enter the number corresponding to the appropriate response.

1 = Less than once a week

2 = 1 to 6 times a week

3 = Once a day

4 = Twice a day

5 = 3 – 11 times a day

6 = every 2 hours

7 = hourly / continuous

S6b. Ventilator / Respirator

This is a required field only available for data entry if O0100F Ventilator or respirator column 2 "While a Resident" is checked. Do **not** include BiPAP/CPAP.

Enter the number corresponding to the appropriate response.

1 = Less than once a week

- 2 = 1 to 6 times a week
- 3 = Once a day
- 4 = Twice a day
- 5 = 3 – 11 times a day
- 6 = 6 – 23 hours
- 7 = 24-hour continuous

S6c. Number of hospitalizations in the last 90 days

This is a required field.

Record the number of times the resident was admitted to hospital with an overnight stay **in the last 90 days** (or since last assessment if less than 90 days). Enter 0 (zero) if no hospital admissions.

Valid range includes 0 – 90.

S6d. Number of emergency room visits in the last 90 days

This is a required field.

Record the number of times the resident visited the Emergency Room (ER) without an overnight stay **in the last 90 days** (or since the last assessment if less than 90 days). Enter 0 (zero) if no ER visits.

Valid range includes 0 – 90.

S6e. Oxygen Therapy

This is a required field only available for data entry if O0100C Oxygen therapy column 2 “While a Resident” is checked.

Enter the number corresponding to the appropriate response.

- 1 = Less than once a week
- 2 = 1 to 6 times a week
- 3 = Once a day
- 4 = Twice a day
- 5 = 3 – 11 times a day
- 6 = 6 – 23 hours
- 7 = 24-hour continuous

S6f. Special Ports/Central Lines/PICC

This is an optional field.

Use this field to indicate if the resident has any type of implantable access system or central venous catheter (CVC). This includes epidural, intrathecal or venous access or Peripherally Inserted Central Catheter (PICC) devices. This does NOT include hemodialysis or peritoneal dialysis access devices.

Enter the corresponding value to the most appropriate response:

N = none present
Y = 1 or more implantable access system or CVC
U = unknown

S6g. At what developmental level is the resident functioning?

Field is correctable.

This is a required field for all assessments on residents under age 21 [based on birth date minus date of submission (TMHP Received date)]. This field is not available for data entry if the resident is 21 years old or older.

Responses included in drop down are:

1. < 1 Infant
2. 1 – 2 Toddler
3. 3 – 5 Pre-School
4. 6 – 10 School age
5. 11 – 15 Young Adolescence
6. 16 – 20 Older Adolescence
- ' – ' Unknown or unable to assess

S6h. Enter the number of times this resident has fallen in the last 90 days

This is a required field.

Record the number of times the resident has fallen in the last 90 days. Enter 0 (zero) if no falls. Each fall should be counted separately. If the resident has fallen multiple times in one day, count each fall individually.

Valid range includes 0 (zero) – 999.

S6i. In how many of the falls listed in S6h above was the person physically restrained prior to the fall?

This is a required field only if S6h indicates the resident has fallen.

Valid range includes 0 (zero) with a maximum being the number entered in S6h.

S6j. In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls, for each contributory factor.)

1 through 6 are required only if S6h indicates the resident has fallen.

Valid range includes 1 (one) with a maximum being the number entered in S6h.

1. Environmental (debris, slick or wet floors, lighting, etc)
2. Medication(s)
3. Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)
4. Poor Balance/Weakness
5. Confusion/Disorientation
6. Assault by Resident or Staff

S7. For DADS Use Only

This section is reserved for DADS

S8. Resident's Current Address

Resident Name is completed on the Minimum Data Set (MDS) at A0500 Legal Name of Resident.

S8a. Resident's Address

Required. Enter the street address where the resident is presently living.
This information is used to mail MN determination letters.

S8b. City

Required. Enter the city where the resident is presently living.
This information is used to mail MN determination letters.

S8c. State

Required. Enter the state where of the resident is presently living.
This information is used to mail MN determination letters.

S8d. ZIP Code

Required. Enter the ZIP code where the resident is presently living.
This information is used to mail MN determination letters.

S8e. Phone

Optional. Enter the contact phone number for the resident if known. If the resident is residing in a Nursing Facility and no other direct contact phone number is known, enter the phone number of the Nursing Facility.

S9. Medications

Medication Certification. I certify this resident is taking no medications OR the medications listed below are correct.

Required. Check the Medication Certification box to verify the resident has no medications OR that the resident has medications and they are listed correctly in the medication table to include name, dose, route of administration (RA), frequency (Freq), and As necessary - number of doses (PRN-n).

The coding instructions are extensive. Review them carefully. Study the examples and complete the coding exercise at the end of this section.

1. Medication Name and Dose Ordered. Identify and record all medications that the resident received in the last 30 days. Also identify and record any medications that may not have been given in the last 30 days, but are part of the resident's regular medication regimen (e.g. monthly B-12 injections). Do not record PRN medications that were not administered in the last 30 days.

Record the name of the medication and dose that was ordered by the physician in column 1. Write the name of the medication and dose ordered EXACTLY as it appears on the Medication Administration Record (MAR). For example, if the MAR indicates Acetaminophen 650 mg, do not write Acetaminophen 325 mg 2 tabs, even if two 325mg tablets are administered to the resident.

Occasionally, dosages of medications may be changed during the 30-Day assessment period or different dosages of the same medication may be given at different times. Each medication with each dosage changes should be recorded separately. For example, a resident received Tegretol 100 mg g am and Tegretol 200 mg g hs. Each of those doses should be documented separately.

Code only medications that the physician orders. If a medication order is carried out off premises, (e.g., a dose administered at a dialysis center), that should be included here. In this example, the nursing facility should be made aware (e.g., via report) of medication administered at the Dialysis Center, but there is no item on the assessment to capture this information. Dialysis itself is captured in P1ab.

If during the observation period, both the generic and the brand name medications were administered (under the same order), it's up to the program to decide which to code. For example, the program may decide to routinely code the generic in such instances. Whatever the decision, it should be carried out consistently. Do not code both a brand and generic name, as it would give the appearance of a double order of the same medication.

If an oral medication is crushed and administered via G-tube, use code 9, enteral tube. Stat orders are coded as 1 in the PRN column.

All medications received by the resident, including over-the-counter medications, should be ordered by the physician and included.

Record the total number of doses, not days, in the last 30 days, which the PRN medication was given.

EXAMPLE FOR 1. MEDICATION NAME AND DOSE ORDERED

Medications as listed on MAR for assessment period of 8/11/10-9/9/10

- A. Lasix 40 mg daily p.o.
- B. Acetaminophen 325 mg 2 tabs q3-4 hrs PRN p.o. (given 3 times in last 30 days)
- C. B-12 1cc q month IM (given 8/8/10)
- D. Isopto Carbachol 1.5% 2 drops OD TID
- E. Robitussin-DM 5cc HS PRN p.o. (not given in last 30 days)
- F. Motrin 300 mg QID p.o. (discontinued 8/15/10)
- G. Dilantin 300 mg HS p.o. (ordered 8/15/10)
- H. Theo-Dur 200 mg BID p.o. (given 8/11-8/13/10 and then order discontinued)
- I. Theo-Dur 200 mg TID p.o. (given 8/14-8/16/10 and then order discontinued)
- J. Theo-Dur 400 mg BID p.o. (given 8/10)

Complete Column 1. as follows:

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Lasix 40 mg			
Acetaminophen 325 mg 2 tabs			
B-12 1cc			
Isopto Carbachol 1.5% 2 drops			
Motrin 300 mg			
Dilantin 300 mg			
Theo-Dur 200 mg			
Theo-Dur 200 mg			
Theo-Dur 400 mg			

*Note that Robitussin-DM was not recorded because it was not given in the last 30 days.

2. Route of Administration. Determine the Route of Administration (RA) used to administer each medication. The MAR and the physician's orders should identify the RA for each medication. Record the RA in column 2 using the following codes:

- 1=by mouth (PO)
- 2=sub lingual (SL)
- 3=intramuscular (IM)
- 4=intravenous (IV)
- 5=subcutaneous (SQ)
- 6=rectal (R)
- 7=topical
- 8=inhalation
- 9=enteral tube
- 10=other

EXAMPLE FOR 2. ROUTE OF ADMINISTRATION

Medications as listed on MAR for assessment period of 8/11/10-9/9/10

- A. Mylanta 15 cc after meals p.o.
- B. Zantac 150 mg q 12 hrs. Per tube
- C. Transderm Nitro patch 2.5 1 patch daily
- D. NPH 15 U before breakfast daily SQ

- E. Lasix 80 mg IV STAT
 F. Acetaminophen suppository 650 mg q 4 hrs. PRN (given on 2 occasions in last 30 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Mylanta 15 cc	1		
Zantac 150 mg	9		
Transderm Nitro patch 2.5 1 patch	7		
NPH 15 U	5		
Lasix 80 mg	4		
Acetaminophen suppository 650 mg	6		

3. Frequency. Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3 using the following codes:

- | | | |
|--------------------------|---|----------------------------|
| PR=(PRN) as necessary | 2D=(BID) two times daily
(includes every 12 hrs) | QO=every other day |
| 1H=(QH) every hour | 3D=(TID) three times daily | 4W=4 times each week |
| | 4D=(QID) four times daily | 5W=five times each week |
| | 5D=five times daily | 3H=(Q3H) every three hours |
| 6H=(Q6H) every six hours | 1W=(Q week) once each wk | 6W=six times each week |
| | 2W=two times every week | 4H=(Q4H) every four hours |
| 1D=(QD or HS) once daily | 3W=three times every week | 1M=(Q mo) once every month |
| | | 2M=twice every month |
| | | 8H=(Q8H) every eight hours |
| | | C=continuous |
| | | O=other |

Be careful to differentiate between similar frequencies. For example, some programs have a policy that antibiotics are to be administered around the clock. Therefore, if an antibiotic is ordered as TID, the medication may actually be given q 8 hours. There is a different frequency code for TID. (3D) and q 8 hrs (8H). In this case, the frequency code would be 8H (q 8 hrs.). If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

EXAMPLE FOR 3. FREQUENCY

Medications as listed on MAR for assessment period of 8/11/10-9/9/10

- A. Ampicillin 250 mg q 6 hrs x 10 days p.o. (8/10-8/20)
 B. Beconase nasal inhaler 1 puff BID
 C. Compazine suppository 5 mg STAT
 D. Lanoxin 0.25 mg p.o. every other day. On alternate days, give Lanoxin 0.125 mg p.o.
 E. Peri-colace 2 capsules HS p.o.
 F. NPH 15 U before breakfast daily SQ
 G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/10 for BS of 255; 5 units given on 8/13/10 for BS of 233; 10 units given on 8/17/10 for BS of 305)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Ampicillin 250 mg	1	6h	
Beconase nasal inhaler 1 puff	8	2d	
Compazine suppository 5 mg	6	PR	
Lanoxin 0.25 mg	1	QO	
Lanoxin 0.125 mg	1	QO	
Peri-colace 2 capsules	1	1D	
NPH 15 U	5	1D	
NPH 5 U	5	PR	
NPH 10 U	5	PR	

4. PRN-Number of Doses (PRN-n). The PRN-n column is only completed for medications that have a frequency as PR. Record the number of times in the past 30 days that each medication coded as PR was given. Stat medications are recorded as a PRN medication. Remember, if a PRN medication was not given in the past 30 days, it should not be listed here.

S9. Medications exercise answer form.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n
Inderal 40 mg	1	2D	
Sinemet 10/100	1	3D	
Artificial Tears 1 drop	7	4D	
Anusol HC suppository 1	6	PR	1
Amoxicillin 500 mg	9	6H	
Benylin cough syrup 2 Tbs	1	PR	10
Darvocet-N 100 2 tabs	1	PR	5
Heparin lock flush 10 U	4	1D	
Ditropan syrup 2.5 mg	1	1D	
Nitrotransdermal .4 mg	7	1D	
Novolin N 24 U	5	1D	
Novolin R 10 U	5	PR	2
Questran 1 packet	1	3D	
Quinine sulfate 325 mg	1	1D	
Coumadin 2.5 mg	1	1D	
Coumadin 5 mg	1	1D	

S10. Comments

Enter up to 500 characters if needed.

It is essential that you include signs and symptoms that present an accurate picture of the resident's condition. The comment section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:

- Pertinent medical history
- Ability to understand medication
- Ability to understand changes in condition
- Abnormal vital signs
- Previous attempts at outpatient management of medical condition
- Results of abnormal lab work.

S11. Advance Care Planning

What is Advance Care Planning?

Advance care planning means planning ahead for how the resident wants to be treated if ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die they are not able to talk or to let others know how they feel.

Advance care planning is a 5-step process that should be discussed with the resident.

1. Thinking about what you would want to happen if you could not talk or communicate with anyone

2. Researching what kind of choices you will need to make if you become very ill at home, in a nursing home or in a hospital
3. Talking with your family and doctor about how you want to be treated
4. Filling out papers that spell out what you want if you are in an accident or become sick
5. Telling people what you have decided

S11a. Does the resident report having a legally authorized representative? Y/N

A Legally Authorized Representative (LAR) is a person authorized by law to act on behalf of a person with regard to a matter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

Required field and correctable.

Enter Y = Yes.

Enter N = No.

S11b. Does the resident report having a Directive to Physicians and Family or Surrogates?

In states other than Texas, this document may be referred to as a Living Will.

Directive to Physician/Living Will is a document that communicates a resident's wishes about medical treatment at some time in the future when he or she is unable to make their wishes known because of illness or injury.

Required field and correctable.

Enter Y = Yes.

Enter N = No.

S11c. Does the resident report having a Medical Power of Attorney?

Required field and correctable.

Enter Y = Yes.

Enter N = No.

S11d. Does the resident report having an Out-of-Hospital Do-Not-Resuscitate Order?

What is an Out-of-Hospital Do Not Resuscitate Order (OOHDNR)?

This form is for use when a resident is not in the hospital. It lets the person tell health care workers, including Emergency Medical Services (EMS) workers, NOT to do some things if the person stops breathing or their heart stops. If a resident does not have one of these forms filled out, EMS workers will ALWAYS give the person Cardiopulmonary Resuscitation (CPR) or advanced life support even if the advance care planning forms say not to. A person should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power of Attorney form if they do NOT want CPR.

Required field and correctable.

Enter Y = Yes.

Enter N = No.

S12. LAR Address

Legally Authorized Representative (LAR) Address is required if S11a. Does the resident report having a legally authorized representative? Is indicated as 1 – Yes.

S12a. LAR First Name

Enter the first name of the Legally Authorized Representative.

S12b. LAR Last Name

Enter the last name of the Legally Authorized Representative.

S12c. Address

Enter the street address of the Legally Authorized Representative.

S12d. City

Enter the city of the Legally Authorized Representative.

S12e. State

Enter the state of the Legally Authorized Representative.

S12f. ZIP Code

Enter the ZIP code of the Legally Authorized Representative.

S12g. Phone

Optional. Enter the contact phone number for the Legally Authorized Representative if known.



